TEXAS REGISTER

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School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

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a section of the
Office of the Secretary of State
P.O. Box 13824
Austin, TX 78711-3824
(800) 226-7199
(512) 463-5561
FAX (512) 463-5569
http://www.sos.state.tx.us
register@sos.state.tx.us

Secretary of State –
Roger Williams

Director - Dan Procter

Staff
Ada Aulet
Leti Benavides
Dana Blanton
Belinda Bostick
Kris Hogan
Roberta Knight
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IN THIS ISSUE

Open Meetings

Statewide agencies and regional agencies that extend into four or more counties post meeting notices with the Secretary of State.

Meeting agendas are available on the *Texas Register*'s Internet site:
http://www.sos.state.tx.us/open/index.shtml

Members of the public also may view these notices during regular office hours from a computer terminal in the lobby of the James Earl Rudder Building, 1019 Brazos (corner of 11th Street and Brazos) Austin, Texas. To request a copy by telephone, please call 463-5561 in Austin. For out-of-town callers our toll-free number is 800-226-7199. Or request a copy by email: register@sos.state.tx.us

For items ***not*** available here, contact the agency directly. Items not found here:

- minutes of meetings
- agendas for local government bodies and regional agencies that extend into fewer than four counties
- legislative meetings not subject to the open meetings law

The Office of the Attorney General offers information about the open meetings law, including Frequently Asked Questions, the *Open Meetings Act Handbook*, and Open Meetings Opinions.
http://www.oag.state.tx.us/opinopen/opengovt.shtml

The Attorney General's Open Government Hotline is 512-478-OPEN (478-6736) or toll-free at (877) OPEN TEX (673-6839).

Additional information about state government may be found here:
http://www.state.tx.us/

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Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or Braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting notice several days before the meeting by mail, telephone, or RELAY Texas. TTY: 7-1-1.

THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, Open Records Decisions.

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: http://www.oag.state.tx.us/opinopen/opinhome.shtml.)

Opinions

Opinion No. GA-0494

Shirley J. Neeley, Ed.D.

Commissioner of Education

Texas Education Agency

1701 North Congress Avenue

Austin, Texas 78701-1494

Re: Whether Education Code §44.031 and §44.033 apply to real and personal property lease-purchase contracts authorized under Local Government Code §271.004 and §271.005 (RQ-0500-GA)

S U M M A R Y

Education Code §44.031 and §44.033 apply to school district lease-purchase contracts entered under Local Government Code §271.004 and §271.005.

Section 44.031 of the Education Code allows a school district to contract for financial consultant services pursuant to chapter 2254, subchapter A of the Government Code, which permits but does not require a financial consultant to be selected through a request for qualifications or similar competitive process. Additionally, the negotiation procedures of Government Code §2254.004 do not apply to contracting with a financial consultant. A school district would not avoid the applicability of §44.031 or §44.033 of the Education Code to a lease-purchase contract under Local Government Code §271.004 or §271.005 by including the services of a financial consultant in the contract.

Opinion No. GA-0495

Mr. Mike Geeslin

Commissioner of Insurance

Texas Department of Insurance

Post Office Box 149104

Austin, Texas 78714-9104

Re: Whether the Texas Department of Insurance is prohibited from disclosing the identities of companies writing commercial property insurance along the Texas coast (RQ-0502-GA)

S U M M A R Y

The Texas Department of Insurance is not prohibited by §38.003(d) of the Insurance Code from disclosing the identities of companies writing commercial property insurance along the Texas coast.

Opinion No. GA-0496

The Honorable Jim Pitts

Chair, Committee on Appropriations

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Education Code §11.168 and its effect on an independent school district's authority to build or pay for infrastructure for new schools within the district (RQ-0503-GA)

S U M M A R Y

Education Code §11.168 does not prohibit an independent school district from paying impact fees imposed by a municipal corporation on the district for the district's new school development.

Education Code §11.168 does not prohibit an independent school district from leasing land and improving it.

Opinion No. GA-0497

The Honorable Ismael "Kino" Flores

Chair, Committee on Licensing and Administrative Procedures

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether the 2006 Qualified Allocation Plan of the Texas Department of Housing and Community Affairs complies with Government Code §2306.6710(b) (RQ-0515-GA)

S U M M A R Y

Government Code §2306.6710(b) is a mandatory provision that requires the Texas Department of Housing and Community Affairs to rank applications using a point system that gives the greatest number of points, in descending order, to the nine factors listed in that section. Section 2306.6710(b) does not permit the department to adopt additional criteria.

Government Code §2306.6710(b)(1)(B) requires the department to score proposed development projects based on input from "neighborhood organizations," which must be on record with the state or county in which the development is to be located and which must represent an area that contains the proposed development site. The 2006 Qualified Allocation Plan from the department defining "neighborhood

organization" to include resident councils, but only to the extent the proposed project is located on property occupied by their residents, is in harmony with §2306.6710(b)(1)(B).

For further information, please access the website at www.oag.state.tx.us or call the Opinion Committee at (512) 463-2110.

TRD-200700002

Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: January 3, 2007

♦ ♦ ♦

PROPOSED RULES

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 1. ADMINISTRATION

PART 3. OFFICE OF THE ATTORNEY GENERAL

CHAPTER 60. TEXAS CRIME VICTIM SERVICES GRANT PROGRAMS

The Office of the Attorney General (OAG) proposes amendments to Subchapter A (General Provisions and Eligibility) §§60.1, 60.3, 60.5 - 60.7, 60.9 - 60.13 and new §§60.14 - 60.17; amendments to Subchapter B (Application, Review and Award Process) §§60.100 - 60.103; Subchapter C (Grant Budget Requirements) §§60.200 - 60.209; and Subchapter D (Required Attachments) §60.300 and §60.301, relating to rules governing certain Texas Crime Victims Services Grant Programs concerning the OVAG and VCLG OAG grant programs. The proposed amendments and new rules will better serve victims of crime by improving the administration of the Texas Crime Victim Services OVAG and VCLG Grant Programs.

According to Article I, Section 31 of the Texas Constitution, the Texas Compensation to Victims of Crime Fund may be expended as provided by law only for delivering or funding victim-related compensation, services, or assistance. Article 56.541(e) of the Texas Code of Criminal Procedure provides that the OAG may use funds from the Texas Compensation to Victims of Crime Fund for grants or contracts supporting crime victim-related services or assistance. Subsection (f) of the Article authorizes the OAG to adopt rules necessary to carrying out the Article's provisions.

The proposed amendments and new rules accurately implement, interpret, and prescribe the law and minimum standards of practices, procedures, and policies of the OAG relating to the administration of the Texas Compensation to Victims of Crime Fund as required by the Administrative Procedures Act, Texas Government Code, Chapter 2001.

Subchapter A (General Provisions and Eligibility, §§60.1, 60.3, 60.5 - 60.7, 60.9 - 60.13)

The proposed amendment to §60.1 adds new definition of "Application Kit," "Applicant," "Claimant," "COG," "Competitive allocation," "CVSD," "Eligible application," "Grantee," "Special condition," "Statewide Program," "Victim," and "Victim-related services or assistance" and renumbers the definitions accordingly.

The proposed amendment to §60.3 clarifies the statutory source of funds.

The proposed amendment to §60.5 changes the title of the section; clarifies the purpose of grant funds and the grant funding decisions; provides that funding decisions will support the efficient and effective use of public funds; and provides that the OAG may award OVAG funds to programs that would otherwise be eligible for funding under another OAG grant program.

The proposed amendment to §60.6 changes the title of the section to "OVAG and VCLG Eligible Purpose Areas; "clarifies grant contracts may be awarded and provides for the use of OVAG funds for victim-related services or assistance and delineates the purposes for the use of OVAG funds to include direct victim services, outreach or community education to help identify victims who might not otherwise be reached and provide or refer them to services, connecting victims to services for the purpose of supporting or assisting in their recovery, training professional and volunteers to improve their ability to inform victims of their rights, assist in their recovery and to establish a continuum of care, provide administrative functions to OAG designated grants, other purposes that are consistent with state and authorized by applicable federal grants or other support for victim-related service or assistance as determined by the OAG. The proposed amendments to §60.6 also clarifies that grant contracts may be awarded and provides for the use of the VCLG funds for victim assistance coordinator and/or crime victim liaison positions for the purposed set forth in the Texas Code of Criminal Procedure, Article 56.04.

The proposed amendment to §60.7 uncapitalizes the term "program".

The proposed amendment to §60.9 changes the title of the section to "Match and Volunteer Requirements," provides that the OAG may require cash and/or in-kind match for grants as stated in the Request for Applications and the Application Kit; that the amount of an award and match requirements are determined solely by the OAG; and the OAG reserves the right to alter the required match for any funded program. The proposed amendment to §60.9 also provides that all non-government OVAG program must have a volunteer component, with the specific requirements for the volunteer component to be stated in the Request for Applications and the Application Kit.

The proposed amendment to §60.10 changes the title of the section to "Funding Levels;" clarifies the minimum amount of funding for VCLG and OVAG programs, clarifies that the OAG may establish different minimum and maximum amounts of funding for an OVAG statewide program; clarifies that grant contracts may be awarded; and provides that the amount of an award is determined solely by the OAG, the OAG may award grants at amounts above or below the established funding levels and is not obligated to fund a grant at the amounted requested.

The proposed amendment to §60.11 changes the title of the section to "Grant Contract Period;" provides generally the grant contract may be awarded for any number of months up to a two year period; and establishes that the grantee, in the event a grant pe-

riod extends for more than one fiscal year, may be required to submit additional documentation relating to a subsequent fiscal year of the grant contract period, including an updated budget; provides that the OAG may base its decision on subsequent fiscal year funding amounts on the grantee's prior performance, including the timeliness and thoroughness of reporting, effective and efficient use of grant funds and the success of the program in meeting its goals.

The proposed amendment to §60.12 establishes that a grant contract is not a right or entitlement and no commitment by the OAG that a grant contract, once funded, will receive subsequent funding.

The proposed amendment to §60.13 changes the title of the section to "Additional Award Opportunities;" clarifies the OAG may fund grant program at amounts higher or lower than provided for in the chapter based on availability of funds and particularized need; and confirms the OAG may award a grant contract or re-designate a grant contract once awarded to a different funding source that the grant for which the applicant filed an application or received funding.

Subchapter A (General Provisions and Eligibility, new §§60.14 - 60.17).

New §60.14 establishes an applicant registration requirement for applicants to register their intent to apply for funding; provides grant application will not be considered if an applicant registration is not timely filed with the OAG; and provides OAG will notify applicant if application is not considered due to failure to timely file applicant registration.

New §60.15 establishes a procedure for filing documents required to be submitted to the OAG; requires that documents must be timely received by the OAG to be considered filed; provides proof of sending a document is not proof of receipt by the OAG; and establishes the final, non-appealable filing decision-making authority of the OAG.

New §60.16 requires that grantees must comply with all applicable state and federal statutes, rules, regulations, and guidelines, including, but not limited to, the Uniform Grant Management Standards (UGMS) and the applicable OMB Circulars and applies those requirements to OVAG and VCLG grants, including grants to non-profit corporations.

New §60.17 provides for the transmittal or required submission of notices, forms or other documents and information via the Internet or other electronic means; and provides that transmission or submission via electronic means satisfies the relevant written requirements.

Subchapter B (Application, Review and Award Process, §§60.100 - 60.103)

The proposed amendment to §60.100 clarifies the OAG will publish a Request for Applications in the *Texas Register* and post it on the OAG's official agency website. The proposed amendment to §60.100 establishes the minimum information to be provided in an Request for Applications, including the applicable funding sources for the types of grants available and eligibility requirements; how to obtain Application Kits; deadlines and filing instructions for the grant application; minimum and maximum amounts of funding available; start date and length of grant contract period; any match or volunteer requirements; award criteria; any prohibitions on the use of grant funds; and OAG contact information. The proposed amendment to §60.100 establishes that after the Request for Applications is published, the Application Kit will be available on the agency's website or an applicant may request an Application Kit from CVSD. The proposed amendment to §60.100 requires an application to be submitted and filed and received by CVSD as established in the Request for Applications. The proposed amendment to §60.100 establishes for a filed application to be initially screened for eligibility, and if eligible, to be evaluated and reviewed, and a grant decision made. The proposed amendment to §60.100 states that providing false information, knowingly or unknowingly, on a grant application may cause an application to be denied or cause the grant contract, once awarded, to be terminated.

The proposed amendment to §60.101 changes the title of the section to "Initial Screening; Evaluation and Review Process;" establishes that applications initially screened as ineligible will not be scored further and establishes the grounds for determining ineligibility to include no timely filed Applicant Registration, application submitted by ineligible applicant; application not filed in the manner and form required by the Request for Applications; application filed after the deadline established in the Request for Applications; or application does not meet other requirements as stated in the Request for Applications and the Application Kit. The proposed amendment to §60.101 allows for the OAG to designate teams to evaluate and review eligible applications; and provides evaluation factors will be developed to assess the award criteria as stated in the Request for Applications and Application Kit. The proposed amendment to §60.101 allows the OAG to contact an applicant to provide additional information. The proposed amendment to §60.101 provides there are several steps in the evaluation and review process and a decision to deny an application may be made at any point during the process.

The proposed amendment to §60.102 changes the title of the section to "Grant Decision Notification Process," clarifies that the OAG will notify the applicant in writing of a grant decision. The proposed amendment to §60.102 provides that the OAG may utilize a grant contract document or a notice of grant document to award a grant and the applicant will be given a deadline to act to accept the grant award and to return the document to the OAG and the failure to return the signed document to the OAG will be construed as a rejection of the grant award, and allows the OAG to de-obligate grant funds. The proposed amendment to §60.102 clarifies that the OAG may add special conditions to the grant award and until the special conditions are satisfied or resolved, they will affect the grantee's ability to receive funds and in some cases, may cause the OAG to de-obligate the grant award.

The proposed amendment to §60.103 changes the title of the section to "Grant Decisions," clarifies that all grant decisions rest completely within the discretionary authority of the OAG; and provides that the award of a grant contract to a program shall not commit or obligate the OAG in any way to make any additional, supplemental, continuation, or other award to that program.

Subchapter C (Grant Budget Requirements, §§60.200 - 60.209)

The proposed amendment to §60.200 lists the eligible budget categories for a grant budget and requires all applicants to submit a completed budget on the OAG prescribed form. The proposed amendment to §60.200 provides that the grants are reimbursement only grants, with grantees being reimbursed for authorized actual expenditures substantiated by documentation submitted to the OAG, as requested and allows the OAG to use alternative payment methods. The proposed amendment to §60.200 does not allow an individual paid with grant funds to re-

ceive dual compensation for the same work, even if the services performed benefit more than one entity. The proposed amendment to §60.200 requires all grantees, including nonprofit entities and local governmental agencies, to follow the rules and requirements of UGMS and all applicable OMB federal circulars. The proposed amendment to §60.200 requires a documented method for allocation of direct costs and adequate supporting receipts and records be maintained. The proposed amendment to §60.200 requires all budget items to be reasonable and necessary and allocated proportionately within each budget category. The proposed amendment to §60.200 provides the OAG is not obligated to fund budget items at the amounts requested or continue to fund budget items once a grant has been awarded.

The proposed amendment to §60.201 clarifies the requirements related to the OAG grant programs. The proposed amendment to §60.201 requires any changes to job duties or employment status of a grant funded position to be reported to the OAG immediately and prohibit the use of grant funds to pay any portion of the salary or any other compensation for an elected government official.

The proposed amendment to §60.202 clarifies the definition of fringe benefits and use of grant funds to pay fringe benefits employees of the grantee identified as part of the grant.

The proposed amendment to §60.203 clarifies the definition of professional and consultant services and use of grant funds for those services. The proposed amendment to §60.203 requires any contract or agreement entered into by a grantee that obligates grant funds to be in writing and consistent with Texas contract law and required grantees to maintain adequate documentation supporting budget items for a contractor's time, services, and rates of compensation and establish a contract administration and monitoring system.

The proposed amendment to §60.204 adds that grant funds may be reimbursed according to Texas State Travel Guidelines and clarifies that travel must relate directly to the delivery of services that supports the program that is funded by the OAG.

The proposed amendment to §60.205 provides that grant funds may not be used to fund the purchase or lease of vehicles.

The proposed amendment to §60.206 clarifies the definition of supplies and use of grant funds by a grant program for those items.

The proposed amendment to §60.207 clarifies the definition of Other Direct Operating expenses and the use of grant funds by a grant program for those items and clarifies that grant funds may not be used to purchase food and beverages.

The proposed amendment to §60.208 no longer allows indirect costs as a budget item for the relevant OAG grant programs.

The proposed amendment to §60.209 clarifies the list of items that are unallowed costs. The proposed amendment to §60.209 clarifies food and beverage costs are limited to those allowed under the Texas State Travel Guidelines and prohibits the use of grants funds to purchase or lease vehicles, pay for travel that is unrelated to the direct delivery of services that supports the OAG funded program or for any unallowable costs set forth in state or federal cost principles.

Subchapter D (Required Attachments, §60.300 and §60.301)

The proposed amendment to §60.300 provides that each Application Kit will have a Comprehensive Certification and Assurances Form and unless otherwise directed by the RFA or the Application Kit, applicants must submit those forms with the grant application. The proposed amendment to §60.301 modifies the list of certifications and assurances to include a Conflict of Interest form and other certifications and assurances required by the OAG.

The proposed amendment to §60.300 provides that the resolution must be submitted at the same time the grant application is submitted by the applicant, unless the RFA or the Application Kit directs otherwise and modifies the specific requirements of the resolution from the applicable governing body, to at least contain authorization for the submission of the grant application and a designation of the name or title of an authorized official who is given the power to apply for, accept, reject, alter, or terminate a grant on behalf of the grantee.

Herman Millholland, Chief, Crime Victim Services Division of the Office of the Attorney General, has determined that for each year of the first five years that the proposal will be in effect, there will be no additional estimated costs to the state and to local governments expected as a result of enforcing or administering the proposed amendments and new sections. Mr. Millholland has determined that for each year of the first five years that the proposal will be in effect, there will be no additional estimated reductions in costs to the state and to local governments as a result of enforcing or administering the proposed amendments and new sections. Mr. Millholland has determined that for each year of the first five years that the proposal will be in effect, there will be no additional estimated loss or increase in revenues to the state or to local governments as a result of enforcing or administering the proposed amendments and new sections. Mr. Millholland has determined that for each year of the first five years that the proposal will be in effect, enforcing or administering the amendments and new sections do not have foreseeable implications relating to cost or revenues of the state or local governments.

Mr. Millholland has determined that for each year of the first five years that the proposal will be in effect, the anticipated public benefit is clarification of existing and modification of existing policies, with the additional public benefit of having a more effective and efficient administration of a state grant fund program for victim-related services and assistance to certain crime victims. Mr. Millholland has determined that for each year of the first five years that the proposal will be in effect, the probable economic cost to persons required to comply with the proposed amendments and new sections is minimal because the proposal does not significantly change the requirements for submitting applications to the OAG for grants or the OAG's administration of the grant programs.

Mr. Millholland has determined that the proposal will not affect a local economy, and therefore, no local impact statement has been drafted.

Mr. Millholland has determined that the proposal will not have an adverse economic effect on small business or micro-businesses.

Comments may be submitted no later than 30 days from the date of publication to Lori Schneider, Assistant Director, Grants and Contracts Program, Crime Victim Services Division, Office of the Attorney General, P.O. Box 12548, Mail Code 005, Austin, Texas 78711-2548, or by telephone (512) 936-1598 or by e-mail to *Lori.Schneider@oag.state.tx.us*.

SUBCHAPTER A. GENERAL PROVISIONS AND ELIGIBILITY

1 TAC §§60.1, 60.3, 60.5 - 60.7, 60.9 - 60.17

The amendments and new sections are proposed under the Texas Code of Criminal Procedure, Article 56.541(f), which authorizes the Office of the Attorney General to adopt rules reasonable and necessary to implement Article 56.541, and in order to use money for grants or contracts that support crime victim-related services or assistance.

The amendments and new sections affect Texas Code of Criminal Procedure, Article 56.541(e).

§60.1. Definitions.

The following terms and abbreviations, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Application Kit--The information that is required to be completed and submitted by an applicant for a grant contract [~~Local criminal prosecutor--A district attorney, a criminal district attorney, a county attorney with felony responsibility, or a county attorney who prosecutes criminal cases~~];

(2) Applicant--An entity that files an application for a grant contract with the OAG [~~Local law enforcement agency--The police department of a municipality or the sheriff's department of any county in this state~~];

(3) Claimant--An individual as defined in the Texas Code of Criminal Procedure, Article 56.32(a)(2) [~~OMB--Office of Management and Budget~~];

(4) COG--Council of Governments, a regional planning commission or similar regional planning agency created under Texas Local Government Code, Chapter 391 [~~OAG--Office of the Attorney General~~];

(5) Competitive allocation--The distribution of grant funds to grantees based on an application process as well as an evaluation and review process [~~RFA--Request for Application~~];

(6) CVSD--Crime Victim Services Division, a division of the Office of the Attorney General [~~UGMS--Uniform Grant Management Standards, published by the Governor's Office of Budget and Planning~~];

(7) Eligible application--An application that meets the minimum requirements set forth in the RFA and Application Kit [~~OVAG--Other Victim Assistance Grants; and~~];

(8) Grantee--An entity or sub-recipient of an entity that receives a grant contract from the OAG; [~~VCLG--Victim Coordinator and Liaison Grants.~~]

(9) Local criminal prosecutor--A district attorney, a criminal district attorney, a county attorney with felony responsibility, or a county attorney who prosecutes criminal cases;

(10) Local law enforcement agency--The police department of a municipality or the sheriff's department of any county;

(11) OAG--Office of the Attorney General;

(12) OMB--Office of Management and Budget;

(13) OVAG--Other Victim Assistance Grants administered by the OAG;

(14) RFA--Request for Applications;

(15) Special condition--A condition placed on a grant because of a need for information, clarification, or submission of an outstanding requirement of the grant that may result in a hold being placed on the OAG funded portion of a grant program. Special conditions may be placed on a grant at any time;

(16) Statewide Program--An entity that actively offers or provides victim-related services or assistance in six or more COG regions;

(17) UGMS--The Uniform Grant Management Standards, promulgated by the Governor's Office of Budget and Planning;

(18) VCLG--Victim Coordinator and Liaison Grants administered by the OAG to provide the victim assistance coordinator and crime victim liaison duties as provided in Texas Code of Criminal Procedure, Article 56.04;

(19) Victim--Unless otherwise allowed by law, an individual as defined in the Texas Code of Criminal Procedure, Article 56.32(a)(11); and

(20) Victim-related services or assistance--Pursuant to the Texas Code of Criminal Procedure, Article 56.32(a)(13), compensation, services, or assistance provided directly to a victim or claimant for the purpose of supporting or assisting the recovery of the victim or claimant from the consequences of criminally injurious conduct.

§60.3. Source of Funds.

[~~Article 56.541(e) of the~~] Texas Code of Criminal Procedure, Article 56.541(e) authorizes the OAG to use money appropriated from [~~to~~] the Texas Compensation to Victims of Crime Fund for grants or contracts supporting victim-related services or assistance. Pursuant to this authorization, the OAG created two types of grant programs, OVAG and VCLG. The source of grant funds for both programs is a biennial appropriation by the Texas Legislature from specified court costs and fees. The funds are constitutionally dedicated. Allocation of funds in the OVAG program is competitive.

§60.5. Purpose of Funds and Grant Funding Decisions.

(a) The purpose of [~~Funds awarded under~~] the OAG VCLG program is [~~are used~~] to fund positions described in [~~Article 56.04 of~~] the Texas Code of Criminal Procedure, Article 56.04 [~~that are related to the provision of direct services for victims of crime. Compensable services and assistance do not include monetary compensation or financial assistance to victims~~].

(b) The purpose of the OAG OVAG program [~~Program~~] is to provide funds, using a competitive allocation method, [~~on a competitive basis~~] to programs that address the unmet needs of victims [~~of violent crime~~] by maintaining or increasing their access to [~~high~~] quality services.

(c) The OAG reserves the right to consider all other appropriations or funding an applicant currently receives when making funding decisions. The OAG may give priority to applicants that do not receive other sources of funding, including funding that originates from the Texas Compensation to Victims of Crime Fund.

(d) The OAG reserves the right to give priority to programs that provide [~~providing~~] direct victim services with grant funds, [~~programs~~] that provide information and education about victims' rights in their community, or [~~and programs~~] that utilize volunteers in providing services.

(e) The OAG reserves the right to give priority to programs that provide [~~providing~~] services in certain geographic or programmatic areas [~~that address the unmet needs of victims of violent crime by maintaining or increasing their access to quality services~~].

(f) Within its discretion, the OAG shall determine the manner and procedure for making funding decisions that support the efficient and effective use of public funds.

(g) The OAG may award OVAG funds to programs that would otherwise be eligible for funding under another OAG grant program.

§60.6. OVAG and VCLG Eligible Purpose Areas.

(a) Grants contracts awarded under the OAG OVAG program may be used for victim-related services or assistance for the following purposes:

(1) providing direct victim services including, but not limited to, counseling, crisis intervention, assistance with Crime Victim's Compensation, legal assistance, victim advocacy, and information and referral;

(2) providing outreach or community education to help identify [helping identify] crime victims who might not otherwise be reached and provide [providing] or refer [referring] them to needed services;

(3) connecting crime victims to services for the purpose of supporting or assisting in their recovery [helping contact crime victims who might not otherwise be reached];

(4) training professionals and volunteers to improve their ability to inform victims of their rights, to assist victims in their recovery, or to establish a continuum of care for victims [connecting crime victims to services and assisting in their recovery];

(5) providing administrative functions to OAG designated grants; [training professionals and volunteers to improve their ability to afford victims their rights as provided by law, to competently assist victims in their recovery, and to establish a continuum of care accessible to all victims of violent crime; and]

(6) other purposes, consistent with state law, that are authorized by applicable federal grants; or [other support for victim services as determined by the OAG.]

(7) other support for victim-related services or assistance as determined by the OAG.

(b) Grant contracts awarded under the OAG VCLG program shall be used for victim assistance coordinator and/or crime victim liaison positions for the purposes set forth in Texas Code of Criminal Procedure, Article 56.04.

§60.7. OVAG Eligible Applicants.

The following entities are eligible to apply under the OVAG program [Program]:

(1) local units of government;

(2) non-profit agencies with 26 U.S.C. §501(c)(3) status; and

(3) state agencies.

§60.9. Match and Volunteer Requirements [Eligible Budget Categories].

(a) The OAG may require cash and/or in-kind match for grants as stated in the RFA and the Application Kit. The amount of an award and the match requirements are determined solely by the OAG. The OAG reserves the right to alter the required match for any funded program. [Eligible budget categories are limited to the following:]

[(1) personnel;]

[(2) fringe benefits;]

[(3) professional and consultant services;]

[(4) travel;]

[(5) equipment;]

[(6) supplies;]

[(7) other direct operating expenses; and]

[(8) indirect costs.]

(b) All non-governmental OVAG programs must have a volunteer component. The specific requirements for the volunteer component will be stated in the RFA and the Application Kit [The description and requirements for each budget category may be found in Subchapter C within this chapter].

§60.10. Funding Levels [and Match].

(a) For [local programs, under] VCLG and OVAG programs, the minimum amount of funding for which an applicant may apply is $20,000 per fiscal year.

(b) The OAG may establish different minimum and maximum amounts of funding for an OVAG statewide program [For statewide programs, under OVAG only, the minimum amount of funding for which an applicant may apply is $20,000 per fiscal year].

(c) The maximum amount of funding for [which] an OVAG and VCLG grant contract will be [applicant may apply is] stated in the RFA and the Application Kit.

(d) The amount of an award is determined solely by the OAG. The OAG may award grants at amounts above or below the established funding levels and is not obligated to fund a grant at the amount requested [The OAG may require cash and/or in-kind match for OVAG and VCLG grants as stated in the RFA and the Application Kit].

[(e) Certain statewide entities may be eligible to apply for pass-through funding on behalf of their local members. Such pass-through funding is subject to different funding limitations from those described in subsections (a) and (b) of this section. Entities wishing to determine whether they are eligible for this type of funding should consult the RFA and Application Kit.]

[(f) The amount of an award and the match required are determined solely by the OAG. The OAG may award grants at amounts above or below the established funding levels and is not obligated to fund a grant at the amount requested. The OAG reserves the right to alter the required match for any funded program.]

[(g) The OAG may require volunteers to be used as an in-kind match and may give priority to applicants who utilize volunteers in their organization.]

§60.11. Grant Contract Period.

(a) Generally, grant contracts may be [Grants are] awarded for any number of months up to a two [one] year period [term] beginning September 1st and ending August 31st.

(b) The OAG reserves the right to alter the starting date and length of the grant contract period [term].

(c) If the grant contract period extends for more than one fiscal year, the grantee may be required to submit additional documentation relating to the subsequent fiscal year of the grant contract period, including an updated budget. The OAG may base its decision on subsequent fiscal year funding amounts on the grantee's prior performance, including but not limited to the timeliness and thoroughness of reporting, effective and efficient use of grant funds and the success of the program in meeting its goals.

§60.12. Continuation of Funding.

Because a grant is not a right or an entitlement, there [There] is no commitment by the OAG that a grant contract, once funded, will receive subsequent funding. [The OAG will have the option to renew the grant for one additional year subject to and contingent on funding, review and approval.]

§60.13. Additional Award Opportunities [Nonstandard Funding].

(a) The [If the OAG determines that it is in the best interest of the state, the] OAG may fund programs [projects] outside the standard application cycle or process or at amounts higher or lower than provided for in this chapter based on availability of funds and a particularized need [and may change a grant to a different funding source if necessary].

(b) The OAG may choose to award a grant contract or re-designate a grant contract once awarded to a different funding source than that grant for which the applicant filed an application or received funding.

§60.14. Applicant Registration.

(a) The OAG may require applicants to register their intent to apply for funding. If registration is required, the deadline to file, including a time, date and place certain, will be given in the RFA.

(b) Grant applications will not be considered if the registration is not filed by the established deadline.

(c) The OAG will notify an applicant if their application will not be considered due to failure of timely registration.

§60.15. Filings with the OAG.

(a) All documents that are required to be submitted to the OAG must be received by the OAG to be considered as filed. If a deadline is established by the OAG, it will include a time, date and place certain.

(b) Proof of sending a document by email or other means is not proof that the OAG received the information.

(c) All filing decisions rest completely within the discretionary authority of the OAG and the decisions made by the OAG are final and are not subject to appeal.

§60.16. Compliance with Other Standards.

(a) Grantees must comply with all applicable state and federal statutes, rules, regulations, and guidelines. In instances where both federal and state requirements apply to a grantee, the more restrictive requirement applies.

(b) The relevant standards include, but are not limited to:

(1) Uniform Grant Management Standards (UGMS) adopted pursuant to the Uniform Grant and Contract Management Act of 1981, Texas Government Code, Chapter 783. These requirements apply to both OVAG and VCLG grants, including grants to non-profit corporations; and

(2) All applicable OMB Circulars, and in particular, OMB Circulars A-21, A-87, A-102, A-110, A-133.

§60.17. Use of the Internet.

(a) The OAG may transmit notices, forms or other documents and information via the Internet or other electronic means.

(b) The OAG may require the submission of notices, forms or other documents and information via the Internet or other electronic means.

(c) Transmission or submission via electronic means meets the relevant requirements contained within this chapter for submitting information in writing.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Stacey Napier
Deputy Attorney General
Office of the Attorney General
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For further information, please call: (512) 936-1841

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SUBCHAPTER B. APPLICATION, REVIEW AND AWARD PROCESS

1 TAC §§60.100 - 60.103

The amendments are proposed under the Texas Code of Criminal Procedure, Article 56.541(f), which authorizes the OAG to adopt rules reasonable and necessary to implement Article 56.541, and in order to use money from the Texas Compensation to Victims of Crime Fund for grants or contracts that support crime victim-related services or assistance.

The amendments affect Texas Code of Criminal Procedure, Article 56.541.

§60.100. Application Process.

(a) The OAG will publish a RFA in the *Texas Register* and post the RFA on the OAG's official agency website at *www.oag.state.tx.us* [After the RFA is published in the *Texas Register,* the application kit will be available on the official agency website at *www.oag.state.tx.us*, or an applicant may request an application kit from the Crime Victim Services Division].

(b) The RFA, at a minimum, will provide the following information: [An applicant for a grant under this chapter must submit an OVAG or VCLG application to the Crime Victim Services Division of the OAG, as referenced in the RFA.]

(1) applicable funding sources for the types of grants available and eligibility requirements;

(2) how to obtain Application Kits;

(3) deadlines and filing instructions for the grant application;

(4) minimum and maximum amounts of funding available;

(5) start date and length of grant contract period;

(6) any match or volunteer requirements;

(7) award criteria;

(8) any prohibitions on the use of grant funds; and

(9) OAG contact information.

(c) After the RFA is published in the *Texas Register,* the Application Kit will be available on the official agency website at *www.oag.state.tx.us*, or an applicant may request an Application Kit from the CVSD [The application kit must be received by the OAG, Crime Victim Services Division, by the deadline stated in the RFA].

(d) An applicant must submit an application to the CVSD, as referenced in the RFA [Providing false information, knowingly or unknowingly, on a grant application may cause an application to be denied or cause the grant, once awarded, to be terminated].

(e) The application, with the required attachments, must be filed and received by the CVSD, by the deadline stated in the RFA.

(f) Once the application is filed, it will be initially screened for eligibility, and if eligible it will be evaluated and reviewed, and a grant decision will be made.

(g) Providing false information, knowingly or unknowingly, on a grant application may cause an application to be denied or cause the grant contract, once awarded, to be terminated.

§60.101. Initial Screening; Evaluation [Scoring] and Review Process.

(a) The OAG will initially screen [review] each [eligible] application for eligibility. Applications that are not eligible will not be scored further and will not be eligible for a grant award. Applications will be deemed ineligible if:[. The OAG may designate a team to evaluate or score eligible applications. The OAG has full authority in making all funding decisions. However, allocation of the funds for the OVAG program shall be competitive based on a process established by the OAG.]

(1) The applicant did not register timely an intent to apply, if required;

(2) The application is submitted by an ineligible applicant;

(3) The application is not filed in the manner and form required by the RFA;

(4) The application is filed after the deadline established in the RFA; or

(5) The application does not meet other requirements as stated in the RFA and the Application Kit.

(b) The OAG may designate teams to evaluate and review eligible applications. The evaluation teams may consist of OAG employees, employees of other state agencies, or other designees. Evaluation factors will be developed to assess the award criteria as stated in the RFA and Application Kit [During the review process, an OAG staff member, or a designee, may contact the applicant for additional information].

(c) During the initial screening or evaluation and review process, an applicant may be contacted to provide additional information [There are several stages of the review process. A decision to approve or deny project funding may be made at any point during that process].

(d) There are several steps in the evaluation and review process. A decision to deny an application may be made at any point during the evaluation and review process.

§60.102. Grant Decision Notification Process.

(a) The OAG shall notify [will inform] the applicant in writing of its decision regarding a grant award.

(b) The OAG may utilize a grant contract document or a notice of grant document once a decision is made to award a grant. The applicant will be given a deadline to act to accept the grant award and to return the appropriate document to the OAG within the time prescribed by the OAG. An applicant's failure to return the signed document to the OAG within the applicable time period will be construed as a rejection of the grant award, and the OAG may de-obligate funds [In an effort to keep the applicants informed, the OAG may post information on the official agency website, *www.oag.state.tx.us*].

(c) The OAG may add special conditions to the grant award. Until satisfied, these special conditions will affect the grantee's ability to receive funds. If special conditions are not resolved, the OAG may de-obligate the entire amount of the grant award [The OAG must receive a written acceptance or rejection of a grant award within 45 calendar days of the date of notification. An applicant's failure to provide written acceptance to the OAG within this time period will be construed as a rejection of the grant award, and the OAG may deobligate funds].

[(d) The OAG may add special conditions to the grant requiring documents to be submitted prior to the reimbursement of any expenses. Special conditions include submission of attachments or justification for certain items. Until satisfied, these special conditions will affect the grantee's ability to receive funds. If special conditions are not resolved, the OAG may deobligate the entire amount of the grant award.]

§60.103. Grant Decisions [Review of Denial].

(a) All grant [funding] decisions, including, but not limited to, eligibility, evaluation and review, and funding rest completely within the discretionary authority of the OAG and the decisions made by the OAG are final and are not subject to appeal.

(b) The award of a grant contract to a program shall not commit or obligate the OAG in any way to make any additional, supplemental, continuation, or other award to that program.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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SUBCHAPTER C. GRANT BUDGET REQUIREMENTS

1 TAC §§60.200 - 60.209

The amendments are proposed under the Texas Code of Criminal Procedure, Article 56.541(f), which authorizes the OAG to adopt rules reasonable and necessary to implement Article 56.541, and in order to use money from the Texas Compensation to Victims of Crime Fund for grants or contracts that support crime victim-related services or assistance.

The amendments affect Texas Code of Criminal Procedure, Article 56.541.

§60.200. General Budget Provisions.

(a) Unless otherwise stated by the Request for Applications and the Application Kit, eligible budget categories are limited to the following categories: [All applicants must submit a budget.]

(1) personnel;

(2) fringe benefits;

(3) professional and consultant services;

(4) travel;

(5) equipment;

(6) supplies; and

(7) other direct operating expenses.

(b) All applicants must submit a completed budget on the form prescribed by the OAG [Grants awarded by the OAG are reimburse-

ment-only grants. Grantees are reimbursed for authorized actual expenditures contained in the documents required to be submitted to the OAG. If necessary, the OAG may use an alternative method of payment].

(c) Grants awarded by the OAG are reimbursement-only grants. Grantees are reimbursed for authorized actual expenditures substantiated by documentation submitted to the OAG, as requested. If necessary, the OAG may use an alternative method of payment [An individual paid with grant funds may not receive dual compensation for the same work, even if the services performed benefit more than one entity].

(d) An individual paid with grant funds may not receive dual compensation for the same work, even if the services performed benefit more than one entity [All grantees, including but not limited to non-profit entities and local government agencies, must follow the rules and requirements as outlined in UGMS and all applicable OMB federal circulars].

(e) All grantees, including but not limited to non-profit entities and local governmental agencies, must follow the rules and requirements as outlined in UGMS, and all applicable OMB federal circulars [An entity must have an allocation plan for budget items that are funded partially with OAG sources or must maintain equivalent receipts and records].

(f) For budget items funded partially by the OAG, an entity must have a documented method for the allocation of direct costs consistent with the benefit received and must maintain adequate receipts and records [All budget items must be reasonable and necessary and be allocated proportionately within each budget category].

(g) All budget items must be reasonable and necessary and be allocated proportionately within each budget category [All contracts or equipment purchases with a value of $25,000 or more must be pre-approved by the OAG].

(h) The OAG is not obligated to fund budget items at the amounts requested by the applicant and is not obligated to continue to fund budget items once a grant has been awarded.

§60.201. Personnel.

(a) The personnel budget category may include salaries of employees only, and not compensation paid to independent contractors. "Employee" is defined as a person under the direction and supervision of the grantee, who is on the payroll of the grantee and for whom the grantee is required to pay applicable income withholding taxes; or a person who will be on the grantee's payroll and for whom the grantee will pay applicable income withholding taxes once the grant is awarded.

(b) Salaries for grant[-]funded positions must be reasonable and comply with the grantee's salary classification schedule. If a grantee does not have a classification schedule, the grantee must maintain documentation supporting that the salary is commensurate with that paid in the geographic area for positions with similar duties and qualifications. In any event, the OAG will determine whether a salary is reasonable and may limit the grant [OAG-] funded portion of any salary.

(c) The OAG may set minimum restrictions on the percentage of salary that may be funded [by the OAG].

(d) A grantee may not use grant funds to pay overtime.

(e) Any changes to the job duties or employment status of a grant funded position must be reported to the OAG immediately.

(f) A grantee may not use grant funds to pay any portion of the salary or any other compensation for an elected government official.

§60.202. Fringe Benefits.

(a) "Fringe benefits" is defined as allowances and services provided by the grantee [an entity] to its employees as compensation in addition to regular salaries and wages. Fringe benefits include, but are not limited to, the costs of leave, employee insurance, pensions, and unemployment benefit plans.

(b) Grant funds may be used to pay fringe benefits of an employee only if grant funds are also being used to pay for the salary of the same employee [salaries].

(c) A grantee must provide grant-funded personnel the same fringe benefits provided to all other non-grant-funded personnel of the grantee.

§60.203. Professional and Consultant Services.

(a) "Professional and consultant services" is defined as any service for which the grantee [entity] uses an outside source for necessary support. Professional and consultant services include, but are not limited to, accounting services, counseling, legal services, and computer support.

(b) Any contract or agreement entered into by a grantee that obligates grant funds must be in writing and consistent with Texas contract law. Grantees must maintain adequate documentation supporting budget items for a contractor's time, services, and rates of compensation. Grantees must establish a contract administration and monitoring system to regularly and consistently ensure that contract deliverables are provided as specified in the contract [All costs for professional and consultant services must follow the guidelines set forth in UGMS].

(c) Grant funds may not be used to pay for any professional and consultant services for a person or vendor who participates directly in writing a grant application.

§60.204. Travel.

(a) Travel expenses may [will] be reimbursed according to the Texas State Travel Guidelines, unless a grantee's travel policy provides a lesser reimbursement.

(b) Travel must relate directly to the delivery of services that supports the program that is funded by the OAG [or to the central focus of the] grant [project].

(c) Grant funds may not be used to pay for out-of-state travel.

§60.205. Equipment.

(a) "Equipment" is defined as an article of non-expendable, tangible personal property having a useful life of more than one (1) year and a per unit acquisition cost which equals the lesser of:

(1) the capitalization level established by the grantee for financial statement purposes;[:] or

(2) $5,000.

(b) A grantee may use equipment paid for with OAG funds only for grant-related purposes and not for personal or non-grant-related purposes.

(c) Grant funds may not be used to fund the purchase or lease of vehicles [All costs for equipment must follow the guidelines set forth in UGMS and OMB circulars].

[(d) Grant funds may not be used to fund the purchase of vehicles.]

§60.206. Supplies.

(a) "Supplies" is defined as consumable items directly related to the day-to-day operation of the grant program [~~project~~]. Allowable items include, but are not limited to, office supplies, paper, postage, and education resource materials.

(b) The OAG will not approve funds for the purchase of program [~~project~~] promotional items or recreational activities.

§60.207. Other Direct Operating Expenses.

(a) "Other direct operating expenses" is defined as those costs not included in other budget categories and which are directly related to the day-to-day operation of the grant program [~~project~~].

(b) Funds may not be used to purchase food and beverages [~~for meetings or program participants~~].

(c) Registration fees for conferences and other training sessions should be included in this category.

§60.208. Indirect Costs.

(a) "Indirect costs" is defined as any cost not directly identified with a single, final cost objective, but identified with two or more final cost objectives or with at least one intermediate cost objective [~~For additional guidelines on "indirect costs," grantees should consult UGMS~~].

(b) The OAG will not fund [~~allow~~] indirect costs for VCLG and OVAG programs [~~unless the grantee submits a cost allocation plan approved by a cognizant agency and the costs are approved by the OAG~~].

~~[(c) The OAG reserves the right to limit indirect costs charged to a grant regardless of an applicant's cost allocation plan.]~~

§60.209. Unallowable Costs.

(a) OAG grant funds may not be used for the following:

(1) to pay overtime, out-of-state travel, dues, or lobbying;

(2) to purchase food and beverages except as allowed under Texas State Travel Guidelines [~~for meetings or program participants~~];

(3) to [~~fund the~~] purchase or lease [~~of~~] vehicles; [~~or~~]

(4) to purchase promotional items or recreational activities;[~~.~~]

(5) to pay for travel that is unrelated to the direct delivery of services that supports the OAG funded program;

(6) to pay consultants or vendors who participate directly in writing a grant application; or

(7) any unallowable costs set forth in state or federal cost principles.

(b) Funds may not be used to purchase any other products or services the OAG identifies as inappropriate or unallowable within the RFA or the Application Kit.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Stacey Napier
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SUBCHAPTER D. REQUIRED ATTACHMENTS

1 TAC §60.300, §60.301

The amendments are proposed under the Texas Code of Criminal Procedure, Article 56.541(f), which authorizes the OAG to adopt rules reasonable and necessary to implement Article 56.541, and in order to use money from the Texas Compensation to Victims of Crime Fund for grants or contracts that support crime victim-related services or assistance.

The amendments affect Texas Code of Criminal Procedure, Article 56.541.

§60.300. Comprehensive Certification and Assurances Form.

(a) Each Application Kit will have a Comprehensive Certification and Assurances Form. Unless otherwise directed by the RFA or the Application Kit, [~~If possible,~~] applicants must[~~should~~] submit a signed Comprehensive Certification and Assurances Form with the grant application. [~~Otherwise, the form must be submitted within the period for acceptance or rejection of a grant as provided in §60.102(c).~~]

(b) The form includes, but is not limited to, the following certifications and assurances:

(1) Equal Employment Opportunity Program Certification;

(2) Certification Regarding Lobbying;

(3) Nonprocurement Debarment Certification;

(4) Drug-Free Workplace Certification;

(5) Audit Certification;

(6) UGMS Certifications;

(7) Certified Assurances; [~~and~~]

(8) Conflict of Interest; and [~~Other certifications deemed necessary by the OAG.~~]

(9) Other certifications and assurances required by the OAG.

§60.301. Resolution.

(a) The resolution permits the applicant to submit an application. Unless otherwise directed by the RFA or the Application Kit, the resolution must be submitted at the same time the grant application is submitted by the applicant [~~The resolution shall be submitted by the applicant before the award or release of funds~~].

(b) The specific requirements for the resolution will be stated in the Application Kit [~~and format for resolutions may be found in the application kit made available after the RFA is published~~].

(c) A resolution from the applicable governing body (such as the City Council, County Commissioners' Court, or Board of Directors) must contain, at a minimum, the following:

(1) authorization for the submission of the grant application to the OAG; and

(2) a designation of the name or title of an authorized official who is given the power to apply for, accept, reject, alter, or terminate a grant on behalf of the grantee.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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CHAPTER 62. SEXUAL ASSAULT PREVENTION AND CRISIS SERVICES

1 TAC §§62.33 - 62.59

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the Office of the Attorney General or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Office of the Attorney General (OAG) proposes the repeal of Title 1, Texas Administrative Code, Chapter 62, §§62.33 - 62.59, relating to Sexual Assault Prevention and Crisis Services, and in particular, the sexual assault and crisis services grant programs of the OAG.

The repeal is proposed to better organize the existing Chapter 62 as well as to allow for the additional provisions and modifications to the rules regarding the sexual assault prevention and crisis services grant programs to be proposed for inclusion in the Chapter 62 in an orderly fashion. These rules are being proposed for repeal and new rules regarding the sexual assault prevention and crisis services grant programs are being proposed elsewhere in this issue of the *Texas Register*.

According to Article I, Section 31 of the Texas Constitution, the Texas Compensation to Victims of Crime Fund may be expended as provided by law only for delivering or funding victim-related compensation, services, or assistance. Article 56.541(e) of the Texas Code of Criminal Procedure provides that the OAG may use funds from the Texas Compensation to Victims of Crime Fund for grants or contracts supporting crime victim-related services or assistance. Subsection (f) of the Article authorizes the OAG to adopt rules necessary to carrying out the Article's provisions.

Chapter 420 of the Texas Government Code, establishes a Sexual Assault Prevention and Crisis Services Fund, and authorizes the OAG to award grants to promote the development throughout the state of locally based and supported nonprofit programs for the survivors of sexual assault and to standardize the quality of services provided. Section 420.004(b) and §420.011, authorizes the OAG to adopt rules necessary to implement the chapter.

The proposed repeal will lead to the development of a more orderly and expanded set of rules of the OAG relating to the administration of the Texas Compensation to Victims of Crime Fund and the Sexual Assault Prevention and Crisis Services Fund, as required by the Administrative Procedures Act, Texas Government Code, Chapter 2001.

Herman Millholland, Chief, Crime Victim Services Division of the Office of the Attorney General, has determined that for each year of the first five years that the proposed repeal will be in effect, there will be no additional estimated costs to the state and to local governments expected as a result of enforcing or administering the proposed repeal. Mr. Millholland has determined that for each year of the first five years that the proposed repeal will be in effect, there will be no additional estimated reductions in costs to the state and to local governments as a result of enforcing or administering the proposed repeal. Mr. Millholland has determined that for each year of the first five years that the proposed repeal will be in effect, there will be no additional estimated loss or increase in revenues to the state or to local governments as a result of enforcing or administering the proposed repeal. Mr. Millholland has determined that for each year of the first five years that the proposed repeal will be in effect, that enforcing or administering the repeal does not have foreseeable implications relating to cost or revenues of the state or local governments.

Mr. Millholland has determined that for each year of the first five years that the proposed repeal will be in effect, the anticipated public benefit is more logically organized and available rules to the public. Mr. Millholland has determined that for each year of the first five years that the proposed repeal will be in effect, there is no probable economic cost to persons required to comply with the proposed repeal.

Mr. Millholland has determined that the proposed repeal of the rules will not affect a local economy, and therefore, no local impact statement has been drafted.

Mr. Millholland has determined that the proposed repeal of the rules will not have an adverse economic effect on small business or micro-businesses.

Comments may be submitted no later than 60 days from the date of publication to Lori Schneider, Assistant Director, Grants and Contracts Program, Crime Victim Services Division, Office of the Attorney General, P.O. Box 12548, Mail Code 005, Austin, Texas 78711-2548, or by telephone (512) 936-1598 or by e-mail to *Lori.Schneider@oag.state.tx.us.*

The repeal is proposed under the Texas Code of Criminal Procedure, Article 56.541(f), which authorizes the Office of the Attorney General to adopt rules reasonable and necessary to implement Article 56.541, and in order to use money for grants or contracts that support crime victim-related services or assistance. The repeal is proposed under the Texas Government Code, §420.004 (b) and §420.011, which authorizes the OAG to adopt rules necessary to implement the Sexual Assault Prevention and Crisis Services Act in order to promote the development throughout the state of locally based and supported nonprofit programs for the survivors of sexual assault and to standardize the quality of services provided.

The proposed repeal of rules affect Texas Code of Criminal Procedure, Article 56.541(e) and Texas Government Code, Chapter 420.

§62.33. Application of Rules.

§62.34. SAPCS Definitions.

§62.35. Source of Funds.

§62.36. Availability of Funds.

§62.37. Purposes of Funding.
§62.38. SAPCS Eligible Applicants.
§62.39. Contract Term.
§62.40. Continuation of Funding.
§62.41. Match and Nonstandard Funding.
§62.42. SAPCS Application Process.
§62.43. SAPCS Scoring and Review Process.
§62.44. SAPCS Contract Award Process.
§62.45. Review of Denial.
§62.46. General Budget Provisions.
§62.47. Eligible Budget Categories.
§62.48. Personnel.
§62.49. Fringe Benefits.
§62.50. Professional and Consultant Services.
§62.51. Travel.
§62.52. Equipment.
§62.53. Supplies.
§62.54. Other Direct Operating Expenses.
§62.55. Indirect Costs.
§62.56. Unallowable Costs.
§62.57. Assurances.
§62.58. SAPCS Contract Forms.
§62.59. Authorized Signator.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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1 TAC §§62.100 - 62.115, 62.200 - 62.203, 62.300 - 62.309, 62.400, 62.401, 62.500, 62.501

The Office of the Attorney General (OAG) proposes new §§62.100 - 62.115, 62.200 - 62.203, 62.300 - 62.309, 62.400, 62.401, 62.500, and 62.501, relating to rules governing the Sexual Assault Prevention and Crisis Services. The new rules relate to the grant programs of the OAG concerning Sexual Assault Prevention and Crisis Services. The new rules will better serve victims of crime by improving the administration of the Sexual Assault Prevention and Crisis Services grant programs.

According to Article I, Section 31 of the Texas Constitution, the Texas Compensation to Victims of Crime Fund may be expended as provided by law only for delivering or funding victim-related compensation, services, or assistance. Article 56.541(e) of the Texas Code of Criminal Procedure provides that the OAG may use funds from the Texas Compensation to Victims of Crime Fund for grants or contracts supporting crime victim-related services or assistance. Subsection (f) of the Article authorizes the OAG to adopt rules necessary to carrying out the Article's provisions.

Chapter 420 of the Texas Government Code, establishes a Sexual Assault Prevention and Crisis Services Fund, and authorizes the OAG to award grants to promote the development throughout the state of locally based and supported nonprofit programs for the survivors of sexual assault and to standardize the quality of services provided. Section 420.004 (b) and §420. 011, authorizes the OAG to adopt rules necessary to implement the chapter.

The new rules accurately implement, interpret, and prescribe the law and minimum standards of practices, procedures, and policies of the OAG relating to the administration of the Texas Compensation to Victims of Crime Fund and the Sexual Assault Prevention and Crisis Services Fund, as required by the Administrative Procedures Act, Texas Government Code, Chapter 2001.

New §62.100 gives definitions for "Applicant," "Application Kit," "COG," "CVSD," "Eligible Application," "Grantee," "OAG," "OMB," "RFA," "SAPCS," "Sexual Assault," "Sexual Assault Program," "Special Condition," "Special Project," "Statewide Program," "Survivor," and "UGMS".

New §62.101 provides that unless otherwise noted, the rules apply to all SAPCS funded sexual assault programs and upon good cause, the rules may be suspended.

New §62.102 provides the source of the state and federal funds.

New §62.103 provides all funding is contingent upon appropriation by the United States Congress and Texas Legislature and approval of OAG.

New §62.104 establishes the purpose of the SAPCS program; the OAG may use a funding formula to determine the amounts of funding; other factors or priorities the OAG may consider in making funding decisions; and provides that funding decisions will support the efficient and effective use of public funds.

New §62.105 provides grant contracts awarded under SAPCS may be used to provide services to survivors and their families for 24-hour crisis hotline; crisis intervention, public education, advocacy and accompaniment to hospitals, law enforcement offices, prosecutors' offices, and courts for survivors and their family members, crisis intervention volunteer training, providing education and training about the nature, scope, and prevention of sexual assault to the public, professionals, students, and volunteers, consistent with an applicable state or federal grant program, providing activities and services to prevent sexual assault or violence, other purposes, consistent with state law, that are authorized by applicable federal grants, and other support for

services to survivors and their families as determined by the OAG. New §62.105 provides the OAG may consult and contract with or award grants to local and statewide programs for special projects to prevent sexual assault and improve services to survivors.

New §62.106 defines the eligible applicants to apply under the SAPCS program; requires the applicant to offer the defined minimum services for at least nine months prior to receiving a SAPCS grant contract; and allows for grant contracts for special projects.

New §62.107 provides that the OAG may require cash and/or in-kind match for grants as stated in the Request for Applications and the Application Kit; that the amount of an award and match requirements are determined solely by the OAG; and the OAG reserves the right to alter the required match for any funded program. New §62.107 also provides that all SAPCS programs must have a volunteer component, with the specific requirements for the volunteer component to be stated in the Request for Applications and the Application Kit.

New §62.108 provides the minimum amount of funding for SAPCS program; provides that the OAG will state the maximum amount of funding in the Request for Applications and the Application Kit; establishes that the OAG may use a funding formula and reserves the right to alter the funding formula; provides that the amount of an award is determined solely by the OAG, grants may be awarded at amounts above or below the established funding levels and the OAG is not obligated to fund a grant at the amounted requested.

New §62.109 provides generally the grant contract may be awarded or any number of months up to a two year period; and establishes that the grantee, in the event a grant period extends for more than one fiscal year, may be required to submit additional documentation relating to a subsequent fiscal year of the grant contract period, including an updated budget; provides that the OAG may base its decision on subsequent fiscal year funding amounts on the grantee's prior performance, including the timeliness and thoroughness of reporting, effective and efficient use of grant funds and the success of the program in meeting its goals.

New §62.110 establishes that a grant contract is not a right or entitlement and no commitment by the OAG that a grant contract, once funded, will receive subsequent funding.

New §62.111 provides for additional award opportunities to fund grant program at amounts higher or lower than provided for in the chapter based on availability of funds and particularized need; and confirms the OAG may award a grant contract or re-designate a grant contract once awarded to a different funding source that the grant for which the applicant filed an application or received funding.

New §62.112 establishes an applicant registration requirement for application to register their intent to apply for funding; provides grant application will not be considered if an applicant registration is not timely filed with the OAG; and provides OAG will notify applicant if application is not considered due to failure to timely file applicant registration.

New §62.113 establishes a procedure for filing documents required to be submitted to the OAG; requires that documents must be timely received by the OAG to be considered filed; provides proof of sending a document is not proof of receipt by the OAG; and establishes the final, non-appealable filing decision-making authority of the OAG.

New §62.114 requires that grantees must comply with all applicable state and federal statutes, rules, regulations, and guidelines, including, but not limited to, the Uniform Grant Management Standards (UGMS) and the applicable OMB Circulars and applies those requirements to SAPCS grants, including grants to non-profit corporations.

New §62.115 provides for the transmittal or required submission of notices, forms or other documents and information via the Internet or other electronic means; and provides that transmission or submission via electronic means satisfies the relevant written requirements.

New §60.200 provides the OAG will publish a Request for Applications in the *Texas Register* and post it on the OAG's official agency website. New §62.200 establishes the minimum information to be provided in an Request for Applications, including the applicable funding sources for the types of grants available and eligibility requirements; how to obtain Application Kits; deadlines and filing instructions for the grant application; minimum and maximum amounts of funding available; start date and length of grant contract period; any match or volunteer requirements; award criteria; any prohibitions on the use of grant funds; and OAG contact information. New §62.200 establishes that after the Request for Applications is published, the Application Kit will be available on the agency's website or an applicant may request an Application Kit from CVSD. New §62.200 require an application to be submitted and filed and received by CVSD as established in the Request for Applications. New §62.200 establishes for a filed application to be initially screened for eligibility, and if eligible, to be evaluated and reviewed, and a grant decision made. New §62.200 state that providing false information, knowingly or unknowingly, on a grant application may cause an application to be denied or cause the grant contract, once awarded, to be terminated.

New §62.201 establishes that applications initially screened as ineligible will not be scored further and establishes the grounds for determining ineligibility to include no timely filed Applicant Registration, application submitted by ineligible applicant; application not filed in the manner and form required by the Request for Applications; application filed after the deadline established in the Request for Applications; or application does not meet other requirements as stated in the Request for Applications and the Application Kit. New §62.201 allows for the OAG to designate teams to evaluate and review eligible applications; and provides evaluation factors will be developed to assess the award criteria as stated in the Request for Applications and Application Kit. New §62.201 allows the OAG to contact an applicant to provide additional information. New §62.201 provides there are several steps in the evaluation and review process and a decision to deny an application may be made at any point during the process.

New §62.202 provides that the OAG will notify the applicant in writing of a grant decision. New §62.202 provides that the OAG may utilize a grant contract document or a notice of grant document to award a grant and the applicant will be given a deadline to act to accept the grant award and to return the document to the OAG and the failure to return the signed document to the OAG will be construed as a rejection of the grant award, and allows the OAG to de-obligate grant funds. The proposed amendment to §62.202 clarifies that the OAG may add special conditions to the grant award and until the special conditions are satisfied or resolved, they will affect the grantee's ability to receive funds

and in some cases, may cause the OAG to de-obligate the grant award.

New §62.203 provides that all grant decisions rest completely within the discretionary authority of the OAG; and provides that the award of a grant contract to a program shall not commit or obligate the OAG in any way to make any additional, supplemental, continuation, or other award to that program.

New §62.300 lists the eligible budget categories for a grant budget and requires all applicants to submit a completed budget on the OAG prescribed form; provides that the grants are reimbursement-only grants, with grantees being reimbursed for authorized actual expenditures substantiated by documentation submitted to the OAG, as requested and allows the OAG to use alternative payment methods. New §62.300 does not allow an individual paid with grant funds to receive dual compensation for the same work, even if the services performed benefit more than one entity. New §62.300 requires all grantees, including nonprofit entities and local governmental agencies, to follow the rules and requirements of UGMS and all applicable OMB federal circulars. New §62.300 requires a documented method for allocation of direct costs and adequate supporting receipts and records be maintained; that all budget items to be reasonable and necessary and allocated proportionately within each budget category and that the OAG is not obligated to fund budget items at the amounts requested or continue to fund budget items once a grant has been awarded.

New §62.301 defines the "Personnel" budget category; requires salaries to be reasonable and comply with the grantee's salary classification schedule or other documentation supporting the salary; the OAG will determine whether a salary is reasonable and may limit the grant-funded portion of any salary or the percentage of salary that may be funded. New §62.301 provides that grants funds may be used to pay overtime; requires any changes to job duties or employment status of a grant funded position to be reported to the OAG immediately and prohibit the use of grant funds to pay any portion of the salary or any other compensation for an elected government official.

New §62.302 defines the "Fringe Benefit" budget category; allows grant funds to pay fringe benefits to employees of the grantee identified as part of the grant and requires that grantee to provide the same fringe benefits to grant-funded personnel that are provide to non-grant-funded personnel.

New §62.303 defines the "Professional and Consultant Services" budget category and use of grant funds for those services. New §62.303 requires any contract or agreement entered into by a grantee that obligates grant funds to be in writing and consistent with Texas contract law and required grantees to maintain adequate documentation supporting budget items for a contractor's time, services, and rates of compensation and establish a contract administration and monitoring system; and that grant funds may not be used to pay for any professional and consultant services for a person or vendor who participates directly in writing a grant application.

New §62.304 defines the "Travel" budget category, provides that travel expenses may be reimbursed according to Texas State Travel Guidelines, unless a grantee's travel policy provides a lesser reimbursement; provides that travel must relate directly to the delivery of services that supports the program that is funded by the OAG; and unless specially authorized, grant funds may not be used to pay for out-of-state travel.

New §62.305 defines the "Equipment" budget category, provides that grantee may use equipment paid for with OAG grant funds for grant-related purposes and not for personal or non-grant-related purposes; and that grant funds may not be used to fund the purchase or lease of vehicles.

New §62.306 defines the "Supplies" budget category and does not allow grant funds to purchase promotional items or recreational activities.

New §62.307 defines the "Other Direct Operation Expenses" budget category, provides that grant funds may not be used to purchase food and beverages and allows registration fees for conferences and other training sessions.

New §62.308 defines the "Indirect Costs" budget category and provides that the OAG will not allow indirect costs as a budget item.

New §62.309 provides a list of items that are unallowed costs.

New §62.400 provides that each Application Kit will have a Comprehensive Certification and Assurances Form and unless otherwise directed by the RFA or the Application Kit, applicants must submit those forms with the grant application. New §62.400 provides a list of the certifications and assurances required by the OAG.

New §62.401 provides that the resolution must be submitted at the same time the grant application is submitted by the applicant, unless the RFA or the Application Kit directs otherwise and modifies the specific requirements of the resolution from the applicable governing body, to at least contain authorization for the submission of the grant application and a designation of the name or title of an authorized official who is given the power to apply for, accept, reject, alter, or terminate a grant on behalf of the grantee.

New §62.500 provides that all required forms will be provided by the OAG and failure to submit the required forms in a timely manner may result in sanctions.

New §62.501 requires that each grant must designate a grant contact who is an employee of the grantee responsible for operating and monitoring the program and able to readily answer questions about the program's day-to-day operations as well as an authorized official, who is the person authorized to apply for, accept, decline, or cancel the grant, signs all grant adjustment requests, inventory reports, progress reports and financial reports as well as any other official documents related to the grant. New §62.501 requires any changes in the grant contact or authorized official to submitted to the OAG immediately.

Herman Millholland, Chief, Crime Victim Services Division of the Office of the Attorney General, has determined that for each year of the first five years that the proposed rules will be in effect, there will be no additional estimated costs to the state and to local governments expected as a result of enforcing or administering the proposed rules. Mr. Millholland has determined that for each year of the first five years that the proposed rules will be in effect, there will be no additional estimated reductions in costs to the state and to local governments as a result of enforcing or administering the proposed rules. Mr. Millholland has determined that for each year of the first five years that the proposed rules will be in effect, there will be no additional estimated loss or increase in revenues to the state or to local governments as a result of enforcing or administering the proposed rules. Mr. Millholland has determined that for each year of the first five years that the proposed rules will be in effect, that enforcing or admin-

istering the rule does not have foreseeable implications relating to cost or revenues of the state or local governments.

Mr. Millholland has determined that for each year of the first five years that the proposed rules will be in effect, the anticipated public benefit is clarification of existing and modification of existing policies, with the additional public benefit of having a more effective and efficient administration of a state grant fund program for victim-related services and assistance to certain crime victims. Mr. Millholland has determined that for each year of the first five years that the proposed rules will be in effect, the probable economic cost to persons required to comply with the proposed rules is minimal because the proposed rules do not significantly change the requirements for submitting applications to the OAG for grants or the OAG's administration of the grant programs.

Mr. Millholland has determined that the proposed rules will not affect a local economy, and therefore, no local impact statement has been drafted.

Mr. Millholland has determined that the proposed rules will not have an adverse economic effect on small business or micro-businesses.

Comments may be submitted no later than 60 days from the date of publication to Lori Schneider, Assistant Director, Grants and Contracts Program, Crime Victim Services Division, Office of the Attorney General, P.O. Box 12548, Mail Code 005, Austin, Texas 78711-2548, or by telephone (512) 936-1598 or by e-mail to *Lori.Schneider@oag.state.tx.us*.

The new rules are proposed under the Texas Code of Criminal Procedure, Article 56.541(f), which authorizes the OAG to adopt rules necessary to implement Article 56.541, and in order to use money for grants or contracts that support crime victim-related services or assistance. The new rules are proposed under the Texas Government Code, §420.004(b) and §420.011, which authorizes the OAG to adopt rules necessary to implement the Sexual Assault Prevention and Crisis Services Act in order to promote the development throughout the state of locally based and supported nonprofit programs for the survivors of sexual assault and to standardize the quality of services provided.

The new rules affect Texas Code of Criminal Procedure, Article 56.541(e) and Texas Government Code, Chapter 420.

§62.100. SAPCS Definitions.

The following terms and abbreviations, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

(1) Applicant--An entity that has filed an application for a grant with the OAG;

(2) Application Kit--The information that is required to be completed and submitted by an applicant for a grant;

(3) COG--Council of Governments, a regional planning commission or similar regional planning agency created under Texas Local Government Code, Chapter 391;

(4) CVSD--Crime Victim Services Division, a division of the Office of the Attorney General;

(5) Eligible Application--An application that meets the minimum requirements set forth in the RFA and Application Kit;

(6) Grantee--An entity or sub-recipient of an entity that receives a grant contract from the OAG;

(7) OAG--Office of the Attorney General;

(8) OMB--Office of Management and Budget;

(9) RFA--Request for Applications;

(10) SAPCS--Sexual Assault Prevention and Crisis Services program administered by the OAG;

(11) Sexual Assault--any act or attempted act as described in the Texas Penal Code, §§21.11, 22.011, 22.021 or 25.02.

(12) Sexual Assault Program--any local public or private nonprofit corporation, independent of a law enforcement agency or prosecutor's office, that is operated as an independent program or as part of a municipal, county, or state agency and that provides the minimum services established in Texas Government Code, Chapter 420;

(13) Special condition--A condition placed on a grant because of a need for information, clarification, or submission of an outstanding requirement of the grant that may result in a hold being placed on the OAG funded portion of a sexual assault program. Special conditions may be placed on a grant at any time;

(14) Special Project--projects to prevent sexual assault and improve services to survivors that may be outside the standard application cycle or process for SAPCS funding.

(15) Statewide Program--An entity that actively offers or provides services in six or more COG regions;

(16) Survivor--an individual who is a victim of sexual assault, regardless of whether a law enforcement report is made or the perpetrator is convicted;

(17) UGMS--The Uniform Grant Management Standards, promulgated by the Governor's Office of Budget and Planning.

§62.101. Construction of Rules.

Unless otherwise noted, these rules apply to all SAPCS funded sexual assault programs. If good cause is established to show that compliance with these rules may result in an injustice to any party, the rules may be suspended at the discretion of the OAG.

§62.102. Source of Funds.

(a) SAPCS funds originate from federal and state sources.

(b) The source of federal funds includes the Federal Department of Health and Human Services, Preventative Health and Health Services Block Grant, Catalog of Federal Domestic Assistance (CFDA) Number 93.991 and Injury Prevention and Control Research and State and Community Based Programs, CFDA Number 93.136. The federal funds are used for grant contracts supporting the prevention of sexual assault or violence.

(c) The source of state funds is a biennial appropriation by the Texas Legislature, these funds are constitutionally dedicated. Texas Code of Criminal Procedure, Article 56.541(e) authorizes the OAG to use money appropriated from the Texas Compensation to Victims of Crime Fund for grant contracts supporting victim-related services or assistance.

(d) Additional funding comes from parole fees pursuant to Texas Code of Criminal Procedure, Article 42.12, Section 19(e) and Texas Government Code, §508.189.

§62.103. Availability of Funds.

All funding is contingent upon the appropriation of funds by the United States Congress and the Texas Legislature and upon approval of an application for funds by the OAG.

§62.104. Purpose of Funds and Grant Funding Decisions.

(a) The purpose of the SAPCS program is to maintain or expand the existing services of a sexual assault program and any other purposes consistent with Texas Government Code, Chapter 420 or other federal grant programs.

(b) The OAG may use a funding formula to determine the amount of funding a sexual assault program may receive in its grant contract.

(c) The OAG reserves the right to consider all other appropriations or funding an applicant currently receives when making funding decisions. The OAG may give priority to applicants that do not receive other sources of funding, including funding that originates from the Texas Compensation to Victims of Crime Fund.

(d) The OAG reserves the right to give priority to sexual assault programs that provide direct victim services with grant funds, that provide information and education about victims' rights in their community, or that utilize volunteers in providing services.

(e) The OAG reserves the right to give priority to sexual assault programs that provide services in certain geographic or programmatic areas.

(f) Within its discretion, the OAG shall determine the manner and procedure for making funding decisions that support the efficient and effective use of public funds.

§62.105. SAPCS Eligible Purpose Areas.

(a) Grant contracts awarded under SAPCS may be used to provide services to survivors and their families for the following purposes:

(1) 24-hour crisis hotline;

(2) crisis intervention;

(3) public education;

(4) advocacy and accompaniment to hospitals, law enforcement offices, prosecutors' offices, and courts for survivors and their family members;

(5) crisis intervention volunteer training;

(6) providing education and training about the nature, scope, and prevention of sexual assault to the public, professionals, students, and volunteers, consistent with an applicable state or federal grant program;

(7) providing activities and services to prevent sexual assault or violence;

(8) other purposes, consistent with state law, that are authorized by applicable federal grants; and

(9) other support for services to survivors and their families as determined by the OAG.

(b) The OAG may also consult and contract with or award grants to local and statewide programs for special projects to prevent sexual assault and improve services to survivors.

§62.106. SAPCS Eligible Applicants.

(a) The following entities are eligible to apply under the SAPCS program:

(1) local units of government, excluding law enforcement agencies and prosecutor's offices;

(2) nonprofit agencies with 26 U.S.C. §501(c)(3) status; and

(3) state agencies.

(b) An applicant must offer the following minimum services for at least nine months prior to receiving a SAPCS grant contract:

(1) 24-hour crisis hotline;

(2) crisis intervention;

(3) public education;

(4) advocacy and accompaniment to hospitals, law enforcement offices, prosecutors' offices, and courts for survivors and their family members; and

(5) crisis intervention volunteer training.

(c) Local and statewide programs may also be eligible to receive SAPCS grant contracts for special projects.

§62.107. Match and Volunteer Requirements.

(a) The OAG may require cash and/or in-kind match for grants as stated in the RFA and the Application Kit. The amount of an award and the match requirements are determined solely by the OAG. The OAG reserves the right to alter the required match for any funded sexual assault program.

(b) All sexual assault programs must have a volunteer component. The specific requirements for the volunteer component will be stated in the RFA and the Application Kit.

§62.108. Funding Levels.

(a) For SAPCS sexual assault programs, the minimum amount of funding for which an applicant may apply is $40,000 per fiscal year or as stated in the RFA and the Application Kit.

(b) The maximum amount of funding for a SAPCS grant contract will be stated in the RFA and the Application Kit.

(c) A funding formula may be used to establish the minimum and maximum amount of funding for the grant contract. The OAG reserves the right to alter the formula or funding method.

(d) The amount of an award is determined solely by the OAG. The OAG may award grants at amounts above or below the established funding levels and is not obligated to fund a grant at the amount requested.

§62.109. Grant Contract Period.

(a) Generally, grant contracts may be awarded for any number of months up to a two year period beginning September 1st and ending August 31st.

(b) The OAG reserves the right to alter the starting date and length of the grant contract period.

(c) If the grant contract period extends for more than one fiscal year, the grantee may be required to submit additional documentation relating to the subsequent fiscal year of the grant contract period, including an updated budget. The OAG may base its decision on subsequent fiscal year funding amounts on the grantee's prior performance, including but not limited to the timeliness and thoroughness of reporting, effective and efficient use of grant funds and the success of the sexual assault program in meeting its goals.

§62.110. Continuation of Funding.

Because the grant contract is not a right or entitlement, there is no commitment by the OAG that a grant contract, once funded, will receive subsequent funding.

§62.111. Additional Award Opportunities.

(a) The OAG may fund sexual assault programs outside the standard application cycle or process or at amounts higher or lower than provided for in this chapter based on availability of funds and a particularized need.

(b) The OAG may choose to award a grant contract or re-designate a grant contract once awarded to a different funding source than that grant for which the applicant filed an application or received funding.

§62.112. Applicant Registration.

(a) The OAG may require applicants to register their intent to apply for funding. If registration is required, the deadline to file, including a time, date and place certain, will be given in the RFA.

(b) Grant applications will not be considered if the registration is not filed by the established deadline.

(c) The OAG will notify an applicant if their application will not be considered due to failure of timely registration.

§62.113. Filings with the OAG.

(a) All documents that are required to be submitted to the OAG must be received by the OAG to be considered as filed. If a deadline is established by the OAG, it will include a time, date and place certain.

(b) Proof of sending a document by email or other means is not proof that the OAG received the information.

(c) All filing decisions rest completely within the discretionary authority of the OAG and the decisions made by the OAG are final and are not subject to appeal.

§62.114. Compliance with Other Standards.

(a) Grantees must comply with all applicable state and federal statutes, rules, regulations, and guidelines. In instances where both federal and state requirements apply to a grantee, the more restrictive requirement applies.

(b) The relevant standards include, but are not limited to:

(1) Uniform Grant Management Standards (UGMS) adopted pursuant to the Uniform Grant and Contract Management Act of 1981, Texas Government Code, Chapter 783. These requirements apply to SAPCS grants, including grants to non-profit corporations; and

(2) All applicable OMB Circulars, and in particular, OMB Circulars A-21, A-87, A-102, A-110, A-133.

§62.115. Use of the Internet.

(a) The OAG may transmit notices, forms or other documents and information via the Internet or other electronic means.

(b) The OAG may require the submission of notices, forms or other documents and information via the Internet or other electronic means.

(c) Transmission or submission via electronic means meets the relevant requirements contained within this chapter for submitting information in writing.

§62.200. Application Process.

(a) The OAG will publish a RFA in the *Texas Register* and post the RFA on the OAG's official agency website at *www.oag.state.tx.us*.

(b) The RFA, at a minimum, will provide the following information:

(1) applicable funding sources for the types of grants available and eligibility requirements;

(2) how to obtain Application Kits;

(3) deadlines and filing instructions for the grant application;

(4) minimum and maximum amounts of funding available;

(5) start date and length of grant contract period;

(6) any match or volunteer requirements;

(7) award criteria;

(8) any prohibitions on the use of grant funds; and

(9) OAG contact information.

(c) After the RFA is published in the *Texas Register*, the Application Kit will be available on the official agency website at *www.oag.state.tx.us*, or an applicant may request an Application Kit from the CVSD.

(d) An applicant must submit an application to the CVSD, as referenced in the RFA.

(e) The application, with the required attachments, must be filed and received by the CVSD, by the deadline stated in the RFA.

(f) Once the application is filed, it will be initially screened for eligibility, and if eligible it will be evaluated and reviewed, and a grant decision will be made.

(g) Providing false information, knowingly or unknowingly, on a grant application may cause an application to be denied or cause the grant contract, once awarded, to be terminated.

§62.201. Initial Screening; Evaluation and Review Process.

(a) The OAG will initially screen each application for eligibility. Applications that are not eligible will not be scored further and will not be eligible for a grant award. Applications will be deemed ineligible if:

(1) The applicant did not register timely an intent to apply, if required;

(2) The application is submitted by an ineligible applicant;

(3) The application is not filed in the manner and form required by the RFA;

(4) The application is filed after the deadline established in the RFA;

(5) The application does not meet other requirements as stated in the RFA and the Application Kit.

(b) The OAG may designate teams to evaluate and review eligible applications. The evaluation teams may consist of OAG employees, employees of other state agencies, or other designees. Evaluation factors will be developed to assess the award criteria as stated in the RFA and Application Kit.

(c) During the initial screening or evaluation and review process, an applicant may be contacted to provide additional information.

(d) There are several steps in the evaluation and review process. A decision to deny an application may be made at any point during the evaluation and review process.

§62.202. Grant Decision Notification Process.

(a) The OAG shall notify the applicant in writing of its decision regarding a grant award.

(b) The OAG may utilize a grant contract document or a notice of grant document once a decision is made to award a grant. The applicant will be given a deadline to act to accept the grant award and to

return the appropriate document to the OAG within the time prescribed by the OAG. An applicant's failure to return the signed document to the OAG within the applicable time period will be construed as a rejection of the grant award, and the OAG may de-obligate funds.

(c) The OAG may add special conditions to the grant award. Until satisfied, these special conditions will affect the grantee's ability to receive funds. If special conditions are not resolved, the OAG may de-obligate the entire amount of the grant award.

§62.203. Grant Decisions.

(a) All grant decisions, including, but not limited to, eligibility, evaluation and review, and funding rest completely within the discretionary authority of the OAG and the decisions made by the OAG are final and are not subject to appeal.

(b) The award of a grant contract to a sexual assault program shall not commit or obligate the OAG in any way to make any additional, supplemental, continuation, or other award to that sexual assault program.

§62.300. General Budget Provisions.

(a) Unless otherwise stated by the Request for Applications and the Application Kit, eligible budget categories are limited to the following categories:

(1) personnel;

(2) fringe benefits;

(3) professional and consultant services;

(4) travel;

(5) equipment;

(6) supplies; and

(7) other direct operating expenses.

(b) All applicants must submit a completed budget on the form prescribed by the OAG.

(c) Grants awarded by the OAG are reimbursement-only grants. Grantees are reimbursed for authorized actual expenditures substantiated by documentation submitted to the OAG, as requested. If necessary, the OAG may use an alternative method of payment.

(d) An individual paid with grant funds may not receive dual compensation for the same work, even if the services performed benefit more than one entity.

(e) All grantees, including but not limited to nonprofit entities and local governmental agencies, must follow the rules and requirements as outlined in UGMS, and all applicable OMB federal circulars.

(f) For budget items funded partially by the OAG, an entity must have a documented method for the allocation of direct costs consistent with the benefit received and must maintain adequate receipts and records.

(g) All budget items must be reasonable and necessary and be allocated proportionately within each budget category.

(h) The OAG is not obligated to fund budget items at the amounts requested by the applicant and is not obligated to continue to fund budget items once a grant has been awarded.

§62.301. Personnel.

(a) The personnel budget category may include salaries of employees only, and not compensation paid to independent contractors. "Employee" is defined as a person under the direction and supervision of the grantee, who is on the payroll of the grantee and for whom the grantee is required to pay applicable income withholding taxes; or a person who will be on the grantee's payroll and for whom the grantee will pay applicable income withholding taxes once the grant is awarded.

(b) Salaries for grant-funded positions must be reasonable and comply with the grantee's salary classification schedule. If a grantee does not have a classification schedule, the grantee must maintain documentation supporting that the salary is commensurate with that paid in the geographic area for positions with similar duties and qualifications. In any event, the OAG will determine whether a salary is reasonable and may limit the grant-funded portion of any salary.

(c) The OAG may set minimum restrictions on the percentage of salary that may be funded.

(d) A grantee may not use grant funds to pay overtime.

(e) Any changes to the job duties or employment status of a grant funded position must be reported to the OAG immediately.

(f) A grantee may not use grant funds to pay any portion of the salary or any other compensation for an elected government official.

§62.302. Fringe Benefits.

(a) "Fringe benefits" is defined as allowances and services provided by the grantee to its employees as compensation in addition to regular salaries and wages. Fringe benefits include, but are not limited to, the costs of leave, employee insurance, pensions, and unemployment benefit plans.

(b) Grant funds may be used to pay fringe benefits of an employee only if grant funds are also being used to pay for the salary of the same employee.

(c) A grantee must provide grant-funded personnel the same fringe benefits provided to all other non-grant-funded personnel of the grantee.

§62.303. Professional and Consultant Services.

(a) "Professional and consultant services" is defined as any service for which the grantee uses an outside source for necessary support. Professional and consultant services include, but are not limited to, accounting services, counseling, legal services, and computer support.

(b) Any contract or agreement entered into by a grantee that obligates grant funds must be in writing and consistent with Texas contract law. Grantees must maintain adequate documentation supporting budget items for a contractor's time, services, and rates of compensation. Grantees must establish a contract administration and monitoring system to regularly and consistently ensure that contract deliverables are provided as specified in the contract.

(c) Grant funds may not be used to pay for any professional and consultant services for a person or vendor who participates directly in writing a grant application.

§62.304. Travel.

(a) Travel expenses may be reimbursed according to the Texas State Travel Guidelines, unless a grantee's travel policy provides a lesser reimbursement.

(b) Travel must relate directly to the delivery of services that supports the sexual assault program that is funded by the OAG grant.

(c) Unless specially authorized by the OAG in writing, grant funds may not be used to pay for out-of-state travel.

§62.305. Equipment.

(a) "Equipment" is defined as an article of non-expendable, tangible personal property having a useful life of more than one (1) year and a per unit acquisition cost which equals the lesser of:

(1) the capitalization level established by the grantee for financial statement purposes: or

(2) $5,000.

(b) A grantee may use equipment paid for with OAG funds only for grant-related purposes and not for personal or non-grant-related purposes.

(c) Grant funds may not be used to purchase or lease vehicles.

§62.306. Supplies.

(a) "Supplies" is defined as consumable items directly related to the day-to-day operation of the sexual assault program. Allowable items include, but are not limited to, office supplies, paper, postage, and education resource materials.

(b) The OAG will not approve funds for the purchase of promotional items or recreational activities for the sexual assault program.

§62.307. Other Direct Operating Expenses.

(a) "Other direct operating expenses" is defined as those costs not included in other budget categories and which are directly related to the day-to-day operation of the sexual assault program.

(b) Funds may not be used to purchase food and beverages.

(c) Registration fees for conferences and other training sessions should be included in this category.

§62.308. Indirect Costs.

(a) "Indirect costs" is defined as any cost not directly identified with a single, final cost objective, but identified with two or more final cost objectives or with at least one intermediate cost objective.

(b) The OAG will not fund indirect costs for SAPCS grants.

§62.309. Unallowable Costs.

(a) OAG grant funds may not be used for the following:

(1) to pay overtime, out-of-state travel, dues, or lobbying;

(2) to purchase food and beverages except as allowed under Texas State Travel Guidelines;

(3) to purchase or lease vehicles;

(4) to purchase promotional items or recreational activities;

(5) to pay for travel that is unrelated to the direct delivery of services that supports the OAG funded sexual assault program;

(6) to pay consultants or vendors who participate directly in writing a grant application; or

(7) any unallowable costs set forth in state or federal cost principles.

(b) Funds may not be used to purchase any other products or services the OAG identifies as inappropriate or unallowable within the RFA or the Application Kit.

§62.400. Comprehensive Certification and Assurances Form.

(a) Each Application Kit will have an Comprehensive Certification and Assurances Form. Unless otherwise directed by the RFA or the Application Kit, applicants must submit a signed Comprehensive Certification and Assurances Form with the grant application.

(b) The form includes, but is not limited to, the following certifications and assurances:

(1) Equal Employment Opportunity Program Certification;

(2) Disclosure and Certification Regarding Lobbying;

(3) Nonprocurement Debarment Certification;

(4) Drug-Free Workplace Certification;

(5) Audit Certification;

(6) UGMS Certifications;

(7) Certified Assurances;

(8) Conflict of Interest; and

(9) Other certifications and assurances required by the OAG.

§62.401. Resolution.

(a) The resolution permits the applicant to submit an application. Unless otherwise directed by the RFA or the Application Kit, the resolution must be submitted at the same time the grant application is submitted by the applicant.

(b) The requirements for the resolution will be stated in the Application Kit.

(c) A resolution from the applicable governing body (such as the City Council, County Commissioners' Court, or Board of Directors) must contain, at a minimum, the following:

(1) authorization for the submission of the grant application to the OAG; and

(2) a designation of the name or title of an authorized official who is given the power to apply for, accept, reject, alter, or terminate a grant on behalf of the grantee.

§62.500. SAPCS Grant Contract Forms.

(a) Unless otherwise stated, all required forms will be provided by the OAG.

(b) Failure to submit the required forms provided by the OAG in a timely manner may result in sanctions as provided in this chapter.

§62.501. Grant Contact and Authorized Official.

(a) Each grant must designate a grant contact. The grant contact must be an employee of the grantee who is responsible for operating and monitoring the sexual assault program and who is able to readily answer questions about the sexual assault program's day-to-day operations. All grant-related information will be sent to the grant contact person.

(b) Each grant must designate an authorized official. The authorized official is the person authorized to apply for, accept, decline, or cancel the grant for the applicant entity. This person signs all grant adjustment requests, inventory reports, progress reports and financial reports as well as any other official documents related to the grant. This person may be, for example, the executive director of the entity, or a county judge, mayor, city manager, assistant city manager, or designee authorized by the governing body in the resolution.

(c) Any changes in the grant contact or authorized official must be submitted in writing to the OAG immediately.

(d) An authorized official may designate alternate persons to sign certain grant documents.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on December 29, 2006.

TRD-200606910

Stacey Napier
Deputy Attorney General
Office of the Attorney General
Earliest possible date of adoption: February 11, 2007
For further information, please call: (512) 936-1841

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 3. TEXAS YOUTH COMMISSION

CHAPTER 91. PROGRAM SERVICES
SUBCHAPTER A. BASIC SERVICES

37 TAC §91.1

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Youth Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Youth Commission proposes the repeal of §91.1, concerning Daily Living. The repeal is being proposed as a result of the commission's annual rule review, which determined that the reason for adopting this rule is more thoroughly addressed in other existing rules, specifically §87.2 and §87.3.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the repeal is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the repeal.

DeAnna Lloyd, Chief of Policy Administration, has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be the elimination of a duplicative agency rule. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the repeal as proposed. No private real property rights are affected by adoption of this rule.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or email to deanna.lloyd@tyc.state.tx.us.

The repeal is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions, and Government Code §2001.039, which requires each state agency to review its rules to determine whether the reason for initial adoption continues to exist, and readopt, readopt with amendments, or repeal a rule as the result of reviewing the rule.

The proposed repeal affects the Human Resources Code, §61.034.

§91.1. Daily Living.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State on December 29, 2006.

TRD-200606912
Dwight Harris
Executive Director
Texas Youth Commission
Earliest possible date of adoption: February 11, 2007
For further information, please call: (512) 424-6014

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CHAPTER 93. YOUTH RIGHTS AND REMEDIES

37 TAC §93.15, §93.33

The Texas Youth Commission proposes amendments to §93.15, concerning youth mail, and §93.33, concerning alleged abuse, neglect and exploitation. The amendments to the rules will update staff titles and other terminology to reflect the TYC Board decision on July 27, 2006, to change the name of the Office of Inspector General to the Office of Youth Care Investigations.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the amendments are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the amendments.

DeAnna Lloyd, Chief of Policy Administration, has determined that for each year of the first five-years the amended sections are in effect the public benefit anticipated as a result of enforcing the sections will be the availability of agency rules reflecting accurate and up-to-date terminology. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the amendments as proposed. No private real property rights are affected by adoption of these rules.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or email to deanna.lloyd@tyc.state.tx.us.

The amendments are proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The proposed rules affect the Human Resources Code, §61.034.

§93.15. Youth Mail.

(a) - (b) (No change.)

(c) Explanation of Terms Used.

(1) Contraband--means any physical item that presents a substantial danger to the safety and security of youth, staff, or the facility and any other item, depiction, or publication that is included in the definition of "contraband" under [~~(GAP)~~] §95.3 of this title [~~(relating to Rules of Conduct)~~].

(2) (No change.)

(3) Special Correspondent--means the following persons:

(A) Texas Youth Commission (TYC) board members, administrators, or TYC inspectors [~~general, or investigators~~];

(B) - (D) (No change.)

(d) - (e) (No change.)

(f) Contraband in Incoming and Outgoing Mail.

(1) - (3) (No change.)

(4) All contraband that is discovered will be seized and disposed of in accordance with [~~(GAP)~~] §97.11 of this title [~~(related to Control of Unauthorized Items Seized)~~]. Money in the mail is handled in accordance with [~~(GAP)~~] §99.31 of this title [~~(relating to Youth Banking)~~].

(g) - (j) (No change.)

§93.33. Alleged Abuse, Neglect and Exploitation.

(a) (No change.)

(b) Applicability.

(1) (No change.)

(2) For procedures regarding the resolution of youth complaints, refer to §93.31 of this title [~~(relating to Complaint Resolution System)~~].

(3) For procedures regarding appeals to the executive director, refer to §93.53 of this title [~~(relating to Appeal to Executive Director)~~].

(4) For procedures regarding reporting the death of a youth, refer to §99.51 of this title [~~(relating to Death of a Youth)~~].

(c) Explanation of Terms Used.

(1) - (4) (No change.)

(5) Deputy Director, Office of Youth Care Investigations [~~Chief Inspector General~~]--the person employed in TYC's Office of Youth Care Investigations [~~General Counsel~~] who is responsible for overseeing investigations of allegations of abuse, neglect or exploitation and compiling investigation information.

(6) Youth Care Investigator [~~Inspector General~~]--the person employed in TYC's Office of Youth Care Investigations [~~General Counsel~~] and located in a TYC facility or district office who is responsible for conducting investigations.

(d) - (f) (No change.)

(g) Referral of the Report to the Youth Care Investigations Deputy Director[~~report to the Deputy Chief Inspector General~~]. By the end of the workday in which a report is received, the facility's CLA will refer the report to the youth care investigations deputy director [~~chief inspector general~~] who will take the following actions before the end of the next working day:

(1) record all reports for tracking; and

(2) assign an investigator.

(h) (No change.)

(i) Investigation Report--Submission and Closure.

(1) Within 15 workdays following the assignment, the investigator will submit the completed investigation report to the youth care investigations deputy director [~~chief inspector general~~]. The youth care investigations deputy director [~~chief inspector general~~] may approve an extension in the time for submission for good cause.

(2) Within five (5) workdays following receipt of the report, the youth care investigations deputy director [~~chief inspector general~~] will review the report and consult with the investigator regarding any necessary additions or clarifications. The youth care investigations deputy director [~~chief inspector general~~] may extend the time for this review if it is required for a thorough and complete report.

(3) The youth care investigations deputy director [~~chief inspector general~~] will indicate whether the report of mistreatment is confirmed or not as follows:

(A) if all the requisite findings for abuse, neglect, or exploitation are affirmed by the evidence, the youth care investigations deputy director [~~chief inspector general~~] will indicate that the report is confirmed as alleged;

(B) if all the requisite findings for abuse, neglect, or exploitation are not affirmed, the youth care investigations deputy director [~~chief inspector general~~] will indicate that the report is not confirmed as alleged. However, if the findings constitute a violation of agency policy or standards of care, even though they do not constitute abuse, neglect, or exploitation, the youth care investigations deputy director [~~chief inspector general~~] may confirm the report as a violation of agency policy or standards of care.

(4) The youth care investigations deputy director [~~chief inspector general~~] will indicate approval of the investigation findings by officially closing the report as confirmed or not confirmed, and referring it to the CLA of the program or facility that generated the allegation.

(5) If the allegation was reported by a medical health provider (MHP) who is employed by or contracts with University of Texas Medical Branch (UTMB) or the Texas Tech University Health Sciences Center (TTUHSC), the MHP will be notified in writing by the youth care investigations deputy director [~~chief inspector general~~] or designee of the results of the investigation and the MHP's right to appeal the findings of the investigation report pursuant to §93.53 of this title.

(j) - (l) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200606914
Dwight Harris
Executive Director
Texas Youth Commission
Earliest possible date of adoption: February 11, 2007
For further information, please call: (512) 424-6014

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CHAPTER 99. GENERAL PROVISIONS
SUBCHAPTER C. MISCELLANEOUS

37 TAC §99.51

The Texas Youth Commission proposes an amendment to §99.51. The amendment to the section will update a staff title to reflect the TYC Board decision on July 27, 2006, to change the name of the Office of Inspector General to the Office of Youth Care Investigations.

Robin McKeever, Assistant Deputy Executive Director for Financial Support, has determined that for the first five-year period the amendment is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the amendment.

DeAnna Lloyd, Chief of Policy Administration, has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be the availability of agency rules reflecting accurate and up-to-date terminology. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the amendment. No private real property rights are affected by adoption of this rule.

Comments on the proposal may be submitted within 30 days of the publication of this notice to DeAnna Lloyd, Chief of Policy Administration, Texas Youth Commission, 4900 North Lamar, P.O. Box 4260, Austin, Texas 78765, or email to deanna.lloyd@tyc.state.tx.us.

The amendment is proposed under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The proposed rule affects the Human Resources Code, §61.034.

§99.51. Death of a Youth.

(a) - (b) (No change.)

(c) On the death of a youth residing in a TYC residential facility, the following actions will be taken.

(1) The following should be notified immediately:

(A) - (D) (No change.)

(E) the director of youth care investigations [~~chief inspector general~~].

(2) The agency will cooperate fully with any external investigation and conduct [~~conducts~~] an internal investigation into the circumstances of the death. The investigation will be conducted in accordance with [~~(GAP)~~] §93.33 of this title [~~(relating to Alleged Abuse, Neglect, and Exploitation)~~], and the report finalized within 25 days of the date of the death of the youth.

(3) The executive director must provide the Attorney General's Office the Custodial Death Report [~~(located www.oag.state.tx.us)~~]. The report must be filed:

(A) regardless of the entity that conducts the investigation;

(B) within 30 days from the date of the death of a youth in any TYC operated or contract residential program; and

(C) with relevant facts surrounding the death.

(4) - (5) (No change.)

(d) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Dwight Harris
Executive Director
Texas Youth Commission
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For further information, please call: (512) 424-6014

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ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the the rule (Government Code, §2001.036). If a rule is adopted without change to the text as published in the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 28. INSURANCE

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 137. DISABILITY MANAGEMENT

The Commissioner of the Division of Workers' Compensation (Division), Texas Department of Insurance, adopts new §§137.1, 137.10, 137.100 and 137.300, concerning disability management including return to work, treatment guidelines, and treatment planning. The sections are adopted with changes to the proposed text as published in the September 1, 2006 issue of the *Texas Register* (31 TexReg 7090).

The new sections, as well as chapter and subchapter title changes, are necessary to implement changes as a result of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session. Sections 137.1, 137.10, 137.100, and 137.300, are necessary to implement HB 7 amendments to Labor Code §413.011 that require the Commissioner of Workers' Compensation (Commissioner) to adopt by rule treatment guidelines that are evidence-based, scientifically valid, outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. The purpose of the treatment guidelines is to ensure the quality of medical care and to achieve effective medical cost control. HB 7 also amended Labor Code §413.011 to require the Commissioner to adopt by rule return to work guidelines for the purpose of enhancing timely and appropriate return to work. HB 7 further amended Labor Code §413.018 to require the Commissioner by rule to provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded. The Commissioner also adopts the new titles of Chapter 137 and Subchapter B.

The Division posted an informal draft of the new sections relating to disability management on February 17, 2006, and invited public input, which included a stakeholder meeting on March 22, 2006. Prior to proposal, the Division considered the merits of various published return to work guidelines and treatment guidelines. Several stakeholder and work group meetings were held to discuss the disability management concept and rules related to guidelines. Meetings were also held with nationally recognized guideline publishers. During a March 23, 2006 meeting, representatives of the various guidelines made presentations to Division staff and workers' compensation system stakeholders regarding the development and use of their individual guidelines. The Division reviewed and evaluated these guidelines, received stakeholder input, and considered the recommendations of the Division's Medical Advisor and the former Texas Workers' Compensation Commission Medical Advisory Committee's Return to Work workgroup. Based on this review and input, the Division made the selection of the most current edition of *The Medical Disability Advisor, Workplace Guidelines for Disability Duration* (MDA), as the Division return to work guideline, and the most current edition of the *Official Disability Guidelines-Treatment in Workers' Comp* (ODG), published by Work Loss Data Institute (WLDI), as Division treatment guidelines.

All system participants benefit from the adopted disability management rules because this chapter establishes a framework to foster, facilitate, and improve communications among injured employees, health care providers, employers, insurance carriers, and the Division by establishing treatment guidelines, planning benchmarks, and return to work goals and time frames. Disability management is a process designed to optimize health care and return to work outcomes for injured employees in an effort to avoid delayed recovery. The adoption of the disability management tools establish defined expectations for system participants. Clarity for system participants should result in fewer disputes and less intervention by the Division.

The MDA provides a basis for health care providers, insurance carriers, injured employees, employers, and the Division to objectively establish or develop return to work goals or a return to work plan, based on guideline established expectancies for disability duration, that include expected return to work time frames for the timely, safe and medically appropriate return of injured employees to productive work. Return to work guidelines establish a framework to foster, facilitate and improve communications among injured employees, health care providers, employers, insurance carriers and the Division regarding return to work goals, expected return to work time frames and proposed job duty and activity modifications. Such communication is essential in returning injured employees to safe, medically appropriate and productive work.

The MDA provides reviewed and updated content. This publication provides disability duration estimates for normal recovery periods, and natural language descriptions of the most common illnesses and injuries of working people. In addition, MDA includes detail on co-morbidities to modify normal recovery periods. Features include: alphabetical listings of diagnoses and procedures; an alphabetical index; a medical code index; a glossary of terms; a section regarding management of medical absences; and diagnosis and procedure topics.

During the time between publication of editions, Reed Group, the publisher, collects information from the users of the MDA to improve and refine the guidelines. This development process includes data collection, topic identification, research and analysis of duration data and development of draft duration tables and manuscripts. The Reed Group's Medical Advisory Board's review and input regarding draft manuscripts is consolidated for publication of the final manuscript.

In evaluating the MDA guideline, the Division considered that the disability duration guidelines published by Reed Group are based on statistical analyses of actual outcome data. The MDA guidelines also integrate clinical judgment and experience, and clinical assessment of the minimum, optimum, and maximum expectancies of disability duration as the most constant variable in predicting a length of disability. In developing the new edition of the MDA, the statistical data used was derived from an additional 1.65 million new disability cases between the years 2001 and 2003.

The Division treatment guidelines outline the frequency and extent of services presumed to be medically necessary and appropriate for a compensable injury. The ODG meets the provisions outlined in Labor Code §413.011(e) that require Division treatment guidelines to be evidence-based, scientifically valid and outcome-focused, and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care.

The ODG guidelines are evidence-based. Labor Code §401.011(18-a) defines "evidence-based medicine" to mean "the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients." The RAND Institute defined *evidence-based* and *peer-reviewed* to mean, at a minimum, a systematic review of literature published in medical journals included in the National Library of Medicine's MEDLINE. RAND, INSTITUTE FOR CIVIL JUSTICE and RAND HEALTH, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* xvi-xviii (2005), available at *www.rand.org* (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*). Finding that systematic reviews of the literature are standard and essential features of an evidence-based guideline development process, RAND determined that ODG was evidence-based and peer-reviewed, criteria for inclusion in the RAND study of treatment guidelines.

The ODG evidence-based guidelines are linked directly to the evidence in the studies and references relevant to the specific treatment conclusion. The publication incorporates abstracts of studies with appropriate references and citations to the complete original research. This evidence is continuously updated by integrating the findings of new studies as they are conducted and released. The ODG treatment guidelines are well known throughout the health care and insurance industries and meet the criteria for inclusion in the National Guideline Clearinghouse (NGC) maintained by the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC requires a clinical practice guideline to meet the criteria for inclusion provided at *www.guideline.gov/about/inclusion.aspx.* For instance, the clinical practice guideline must contain systemically developed statements that include recommendations, strategies, or information that assists physicians, other health care practitioners, and patients in making decisions about appropriate health care for specific clinical circumstances. A clinical practice guideline must have been produced under the auspices of medical specialty associations, relevant professional societies, public or private organizations, government agencies at the Federal, State, or local level, or health care organizations. A clinical practice guideline developed and issued by an individual not officially sponsored or supported by one of the above types of organizations does not meet the inclusion criteria for NGC. Corroborating documentation must have been produced and verified that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development. A guideline will be included in NGC if corroborating documentation can be produced and verified detailing specific gaps in scientific evidence for some of the guideline's recommendations. Additional requirements for NGC inclusion are that the full text of the guideline must be available upon request in print or electronic format, in the English language, and the guideline must be current and the most recent version produced.

The ODG is comprehensive. Based on representations by WLDI, ODG covers conditions that represent over 99% of workers' compensation costs. The ODG allows health care providers and insurance carriers access to treatment information in one comprehensive and consistently organized source. This comprehensive approach enhances the usability of the guidelines and facilitates a consistent application of the guidelines in claims management systems and utilization review processes.

ODG contains prescreened links on their website to treatment resources concerning many workers' compensation conditions. The links are followed by a short description or excerpt from each of the website's contents, which will allow health care providers to quickly provide injured employees with personalized, patient-friendly information pertaining to recovery by printing the most relevant pages. This offers the patient information describing the injury, self-help methods for speeding recovery and suggested therapies for regaining functionality and productivity.

The ODG guidelines are scientifically valid. ODG follows the steps integral to the process of creating evidence-based treatment guidelines. WLDI describes its methodology for formulating the ODG treatment guidelines in the Work Loss Data Institute, ODG Methodology Outline at *www.odg-disability.com/methodology_outline.pdf*. ODG includes a detailed document entitled *Appendix, ODG Treatment in Workers' Comp, Methodology Description Using the AGREE Instrument*, 1571-1582 (2006). This Appendix provides an extensive explanation of how ODG Treatment meets each of the 23 criteria established by the *AGREE* instrument, including the quality domain describing the rigorous means of developing guidelines. The *AGREE* instrument is an appraisal instrument used to evaluate treatment guidelines after they have been developed. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*, p. 29). The RAND study determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* p. 32).

The ODG guidelines are outcome-focused. The information in ODG is a compilation of the current medical evidence that reflects the outcomes of new studies and clinical trials. This data is integrated into the guidelines to reflect advances in medical technology, drug therapies, or alternative medicine techniques. Application of this information in a clinical setting has a positive impact in shaping injured employee return to work outcomes. The *ODG Foreword* notes that studies included in the ODG are focused on determining what is best for the injured employee. Additionally, the *ODG Foreword* reports the results of a study conducted in Ohio by CompManagement, Inc. The pilot study found that "following adoption of ODG statewide, results at CompManagement demonstrate[d] savings in medical costs of 64 percent, in lost days of 69 percent, and minimized treatment delays."

Further, the ODG guidelines are designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care by providing clear data on optimum frequency and duration of treatments. The ODG treatment guidelines explain that claims should ideally be managed based on the details of the case using the "Procedure Summary." The ODG Procedure Summary includes possible therapies and diagnostic methods, and provides a summary and reference to the most recent medical evidence with an indication of whether the procedure is recommended, not recommended, or under study. Within a Procedure Summary, ODG provides guidelines for instruction that include specific utilization review criteria often presented in an algorithmic format. Quality and timely care in workers' compensation cases have become synonymous with overall cost containment. The level of cost containment is directly proportional to the degree of over-utilization of medical treatment currently experienced within the system. Therefore, ODG satisfies the statutory requirement for adoption of treatment guidelines in the State of Texas.

Treatment planning promotes appropriate management of work-related injuries or conditions by the treating doctor. The treating doctor assumes an essential role in the coordination of care on behalf of an injured employee. In accordance with Labor Code §408.023(l) and §408.025(c), the responsibility of a treating doctor to effectively manage and maintain efficient utilization of health care is fulfilled through the process of treatment planning. Treatment planning fosters a framework for the treating doctor to facilitate and improve communications among injured employees, health care providers, employers, insurance carriers, and the Division. The Division expects the treatment planning process to lead to consensus between the treating doctor and insurance carrier regarding health care to be provided. In a situation where the referral doctor becomes primarily responsible for the employee's health care for a work-related injury, the injured employee may complete and submit a change of doctor form to the Division requesting that the referral doctor become the treating doctor in accordance with Labor Code §408.022, and §126.9 (relating to Choice of Treating Doctor and Liability for Payment) and §180.22 (relating to Health Care Provider Roles and Responsibilities). If the referral doctor agrees to become the treating doctor and the Division grants the employee's request to change treating doctors, the "new" treating doctor will assume the responsibility of treatment planning.

Following publication of the proposed new sections in the *Texas Register* on September 1, 2006, the Division held a public hearing on October 5, 2006, and received comments suggesting changes to the sections as published. In response to comments made at the hearing and written comments from interested parties, the Commissioner is adopting these sections with some changes to the proposal as published. Throughout the adopted sections, the Division has made editorial and grammatical changes for clarity. The adopted sections should be read in conjunction with Labor Code §413.011 and §413.018, and other statutes and sections as applicable.

§137.1. In subsection (a), as a result of commenters questioning whether the proposed rules apply to every claimant or only when there is a finding that the injured employee is at risk for delayed recovery, the Division deleted the proposed term *at risk for* and substituted the phrase *to avoid* to indicate that all injured employees not subject to a certified workers' compensation network are included in the disability management concept in order to avoid delayed recovery. In subsection (d), in response to a few comments to include provisions of §133.308 (relating to Medical Dispute Resolution by an Independent Review Organization) the Division deleted language regarding scientific medical evidence and the submission of documentation for dispute resolution as those criteria would be duplicative of the requirements of §133.308.

§137.10. In subsection (a), in response to a comment to clarify that system participants should not reference the treatment information in the MDA, the Division added the phrase "excluding all sections and tables relating to rehabilitation, (MDA), published by the Reed Group, Ltd.," to clarify that the use of the MDA is limited to the disability duration values as guidelines for the evaluation of expected return to work time frames. In subsection (e), in response to comments questioning the potential use of MDA to reduce or deny benefits, the Division changed the language to indicate that, in accordance with Labor Code §409.022, Division return to work guidelines may not be used as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. In subsection (f), in response to a comment questioning the standard for evidence-based medicine in establishing disability durations for diagnoses not included in the guidelines, the Division added language to clarify that for diagnoses or injuries not addressed by the Division return to work guidelines, system participants shall apply the principles of evidence-based medicine to establish disability duration parameters and return to work goals. In subsection (g), in response to a comment requesting sufficient time to implement necessary system changes, the Division added an effective date of May 1, 2007, for consistency with §137.100 and §137.300.

§137.100. In subsection (a), in response to a comment requesting clarification to exclude ODG return to work references when using the ODG treatment guidelines, the Division added language to indicate exclusion of the ODG return to work pathways. In subsections (a), (d), and (f), in response to comments requesting clarification of the relationship between treatment guidelines, treatment planning, and preauthorization, the Division added language to clarify that treatments or services may be provided if preauthorized in accordance with §134.600 (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

§137.300. In response to comments requesting the deletion of proposed subsection (d) which provided for preauthorization requests for care within the guidelines, the Division removed the permissive language and re-lettered the subsections. In subsection (f), in response to comments requesting clarification of the relationship between treatment guidelines, treatment planning, and preauthorization, the Division revised the subsection to clarify the treatment planning process. In subsection (h), in response to comments requesting a sufficient time frame for the effective date of implementation, the Division changed the date of the applicability of this rule to May 1, 2007.

§137.300. In response to many comments concerning treatment planning, the Division added the term *Required* prior to *Treatment Planning* in the section title to duplicate terminology used in §134.600. In subsection (a), in response to a comment recommending a substitution of the term *reasonably* for *all*, the Division added *reasonably* prior to the term *all*. In the same subsection, in response to comments questioning the duration of a treatment plan, the Division deleted the phrase *specified period of time* and added language clarifying that treatment plans shall include treatments and services *for a minimum of 30 days*.

In response to commenters' concern regarding when treatment plans are required, the Division added language in subsection (a)(1) establishing that treatments and services anticipated to exceed or not included in Division treatment guidelines or Division treatment protocols will require treatment planning if *the treatment or service will be provided after the greater of: (A) 60 days from the date of injury; or (B) the optimum days listed in §137.10 of this title (related to Return to Work Guidelines)*. In subsection (a)(2), the Division added the phrase *or Division protocols* after the term *Division treatment guidelines*. Also in subsection (a)(2), in response to a comment recommending the deletion of the reference to return to work guidelines since the lack of a diagnosis being included in the Division's return to work guidelines is not relevant when addressing the appropriateness and medical necessity of health care in the Texas Workers' compensation system, the Division deleted the phrase *or Division return to work guidelines*. In subsection (b), in response to requests from commenters for the removal of permissive language allowing preauthorization requests through treatment planning for care that is within the treatment guidelines, the Division deleted the phrases *treating doctor may submit a treatment plan and to the insurance carrier for approval.* In the same subsection, the Division added the phrases *a treatment plan is not required* and *unless the treatments or services are submitted as part of a treatment plan in accordance with subsection (a) of this section* to clarify that a treatment plan for care within the guidelines is not required unless the treatments or services are submitted as part of a comprehensive treatment plan to indicate all of the care the injured employee will receive. In response to comments requesting clarification about treatments and services on the preauthorization list versus treatment planning, the Division added language in subsection (c) to clarify that specific treatments and services listed in §134.600 may be submitted for preauthorization through a health care provider by following the requirements of §134.600. However, subsection (c) clarifies that even if a treatment or service is on the preauthorization list in §134.600, a health care provider must coordinate with the treating doctor to submit a treatment plan if any of the requirements of §137.300(a) apply. In subsection (d), in response to comments concerning the responsibilities of treating doctors and health care providers in the treatment planning process, the Division added the phrase *and identifies services that require a treatment plan pursuant to subsection (a) of this section, the health care provider shall confer with the treating doctor to develop the required treatment plan in accordance with subsection (a) of this section,* and removed the phrase *the health care provider shall submit the treatment plan to the treating doctor for submission to the insurance carrier.* In accordance with Labor Code §§401.011(42), 408.021(c), 408.023(j), and 408.025(c), and in response to comments regarding the responsibilities of a treating doctor in the treatment planning process, the Division added new subsections (e) and (f) to clarify that the treating doctor serves as the focal point for health care provided to an injured employee by health care providers that are not the treating doctors. Subsection (e) provides that the treating doctor shall confer with the health care providers, insurance carriers, employers, or injured employees as necessary to develop the treatment plan. The treatment plan is required to include the identity and contact information of the health care providers involved in the delivery of health care proposed in the treatment plan. Subsection (f) states that the treating doctor shall inform the parties identified in subsection (e) of the approval or denial of the treatment plan. In subsection (g), in response to comments requesting a sufficient time frame for the effective date of implementation, the Division changed the date of the applicability of this rule to May 1, 2007.

The title of Chapter 137 is changed to "Disability Management" to better encompass all of the adopted subchapters and rules, in addition to future rulemaking initiatives under the umbrella of the disability management philosophy. In addition, the title of Subchapter B is changed to "Return to Work" to broaden the scope of the rules contained in this subchapter. Chapter 137 is divided into four subchapters: General Provisions; Return to Work; Treatment Guidelines; and Treatment Planning.

Section 137.1 describes disability management as a process designed to optimize health care and return to work outcomes for injured employees to avoid delayed recovery in the Texas workers' compensation system. This section explains how disability management tools should be applied in the workers' compensation system. This section also addresses the relationship between these tools and other utilization review or adjudication processes.

Section 137.10 identifies the most current edition of *The Medical Disability Advisor, Workplace Guidelines for Disability Duration* (MDA), excluding all sections and tables relating to rehabilitation, as the Division return to work guidelines for the evaluation of expected or average return to work time frames. The section provides information on how to obtain a copy of the return to work guidelines. The section provides that the Division return to work guidelines are presumed to be a reasonable length of disability duration. The section specifies the use of the return to work guidelines by health care providers, insurance carriers, injured employees, and employers. The section permits the consideration of co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when establishing return to work goals or revising expected return to work durations and goals. The section states that disability durations in the guidelines are not absolute values and do not represent specific periods of time at which an injured employee must return to work; instead, the values represent points in time at which additional evaluation may occur if an injured employee has not experienced a full medical recovery and returned to work. The section establishes that for all diagnoses and injuries not addressed by the Division return to work guidelines, system participants are required to establish disability duration parameters in accordance with the principles of evidence-based medicine. Further, the section prohibits an insurance carrier from using the return to work guidelines as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. This section is effective on or after May 1, 2007.

Section 137.100 identifies the most current edition of the *Official Disability Guidelines-Treatment in Workers' Comp* (ODG), published by Work Loss Data Institute, as Division treatment guidelines, with the exclusion of the return to work pathways. The section requires health care providers to provide treatment in accordance with the Division treatment guidelines unless the treatment or service requires preauthorization in accordance with §134.600 or §137.300. The section provides information on how to obtain a copy of the Division treatment guidelines. The section provides that health care provided in accordance with the Division treatment guidelines is presumed reasonable and is also presumed to be health care reasonably required. The section also establishes that for health care not provided in accordance with the Division treatment guidelines, an insurance carrier is

only liable for the costs of those treatments or services when provided in a medical emergency or if the treatments and services were preauthorized in accordance with §134.600 or §137.300. The section allows the insurance carrier to retrospectively review health care provided within the Division treatment guidelines, and if appropriate, deny payment when the insurance carrier asserts that health care provided was not reasonably required. The section further requires an insurance carrier to support its assertion with documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017. Section 137.100 informs health care providers that preauthorization in accordance with §134.600 or submission of a treatment plan in accordance with §137.300 may be required when proposed treatments and services exceed, or are not included, in the treatment guidelines. The section prohibits an insurance carrier from denying treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols. The section applies to health care provided on or after May 1, 2007.

Section 137.300 requires treatment planning for certain circumstances. The section requires the identification of all reasonably anticipated health care treatment and services to be provided to the injured employee for a minimum of 30 days in a treatment plan. The section provides that treatment plans remain consistent with the principles of evidence-based medicine and health care reasonably required. The section further provides that when a treatment plan is required, a treating doctor shall submit the treatment plan for preauthorization. Section 137.300 states that when a health care provider identifies treatments and services that require preauthorization in accordance with §134.600, the treatments and services may be submitted for preauthorization by a health care provider in accordance with §134.600 unless the health care is submitted as part of a treatment plan in accordance with §137.300(a). Therefore, specific treatments and services listed in §134.600 may be submitted for preauthorization through a health care provider by following the requirements of §134.600. However, the section provides that even if a treatment or service is on the preauthorization list in §134.600 a treatment plan is required if any of the criteria of §137.300(a) apply. The section provides that a treating doctor shall submit a treatment plan to the insurance carrier for preauthorization. The section specifies that if the health care provider is not the treating doctor and identifies services that require a treatment plan, the health care provider shall confer with the treating doctor to develop the required treatment plan. Section 137.300 provides that the treating doctor shall confer with the health care providers, insurance carriers, employers, or injured employees, as necessary to develop the treatment plan with the identity and contact information of the health care providers involved in the delivery of care proposed in the treatment plan. The section requires the treating doctor to inform the health care providers of the approval or denial of the treatment plan. Section 137.300 applies to health care provided on or after May 1, 2007.

These adopted sections do not apply to networks certified under Insurance Code Chapter 1305 pursuant to Labor Code §413.011(g) or political subdivisions with contractual relationships under Labor Code §504.053(b)(2).

§134.650: Commenters recommend the simultaneous repeal of rule 134.650, as that rule undermines the effectiveness of the disability management process, utility of the treatment guidelines, and increase in medical costs to the system.

Agency Response: The Division disagrees that the simultaneous repeal of §134.650 is required at this time, and may consider this recommendation at a time after the implementation of treatment and return to work guidelines.

General: Commenter states that the success of the Division's ability to bring doctors back into the system is dependent on the treatment of legitimately injured employees within reasonable time frames, without hassles, as opposed to no treatment at all.

Agency Response: Based on numerous stakeholder meetings the Division understands that there are many factors that impact the willingness of health care providers to practice in the workers' compensation system. Administrative burdens are of particular importance. The Division's position is that implementation of the disability management rules and concept will provide a framework to improve treatment and return to work outcomes for injured employees. Administrative burdens should ultimately decrease through the consistent application of these tools.

General: Commenter encourages the Division to consider comments received on proposed rules in order to remove barriers to reimbursement for physicians.

Agency Response: The Division appreciates all commenters' recommendations and changes are made from proposal based on comments received. The Division anticipates these rules will facilitate system operations and bring more certainty to the medical billing and reimbursement process.

General: Commenters support the adoption of return to work guidelines and in general support the concept of treatment guidelines and treatment planning. These rules should result in increased communication among system participants and improved return to work outcomes for injured employees. Another commenter states the proposed rules should contribute positively to the effective and efficient treatment of injured employees, reduce treatment and return to work disputes, and help foster prompt and appropriate return to work. A commenter specifically supports the goals and aims of the proposed rules. By emphasizing evidence-based guidelines, outcomes for all system participants can be optimized.

Agency Response: The Division appreciates the support.

General: Commenter recommends that treatment guidelines be implemented appropriately and used to improve health care delivery, and not be used improperly as a standard of care, or by agents to deny medically necessary care.

Agency Response: The Division anticipates health care providers and insurance carriers will integrate the disability management concepts to assure effective and efficient health care and promote early and appropriate return to work for injured employees. The Division agrees that the adopted guidelines only establish benchmarks for use in the system. Individual claims may require more or less treatment, or more or less recovery time based on the specifics of the injury. The disability management rules recognize this and a variance from the guidelines should be supported by documentation. In addition, the Division believes that treatment guidelines alone do not establish the legal standard of care for a physician in Texas but may provide the courts with a benchmark by which to determine clinical conduct in the workers' compensation system. Further, Labor Code, §413.011(e) prohibits the denial of treatment solely on the basis that the proposed treatment is not specifically addressed by the treatment guidelines. The

Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

General: Commenters opine that extensive education of system participants is required if the guidelines are going to be used as intended by their authors and the Division.

Agency Response: The Division agrees that education is an important component and is developing initiatives to educate system participants on the appropriate application of the rules and guidelines.

General: Commenter recommends that if TDI adopts both MDA and ODG guidelines it should make them available on the Division's website so that any updates are instantly accessible. MDA and ODG could obtain a user fee from TDI for the use of their guidelines. Commenter expresses concern over the conflict of interest in adopting guidelines, then forcing the health care provider community to purchase the costly guidelines in order to have access to the information.

Agency Response: The Division is unable to pursue the recommendation as it is beyond the scope of this rulemaking activity. Further, no discussions took place with the vendors on this topic and no "user fee" funds are in the TDI's budget.

General: Commenters recommend a single product, ODG, to be used by system participants because two guidelines create an undue financial burden on stakeholders.

Agency Response: The position of the Division is that despite the cost, the use of two products, MDA for the Division's return to work guidelines and ODG for the Division's treatment guidelines, best serves the needs of injured employees to facilitate early and appropriate return to work.

General: Commenter recommends independent review organization (IROs), who will determine medical necessity of treatment plans, be additionally trained at a designated doctor level so they understand the complexity of these claims and the rehabilitative potential of stay-at-work/return-to-work planning. Additionally, commenter recommends consideration be given for using trained, matched health care providers in the discernment of treatment planning disputes.

Agency Response: The Division agrees that IROs should be completely familiar with the Division's adopted disability management rules. However, it is outside the scope of statutory authority to regulate IROs through the disability management rules. The Division disagrees with the recommendation regarding matching health care providers. Standards related to the prospective review or retrospective review of medical care are currently defined in the Insurance Code Article 21.58A and Division rules and no additional clarification is needed in these rules. In addition, Insurance Code, Article 21.58A includes the requirements for peer-to-peer reviews.

General: Commenters recommend that as disability management rules are implemented, adjustments must also be made to the general medical fee schedule. Commenter suggests designated doctors and IROs reimbursement be considered for adjustment. Commenter states this would allow for continued adequate access to quality health care providers.

Agency Response: The Division agrees and adjustments to §134.202 may be required as disability management concepts are fully integrated into the workers' compensation system. The responsibilities of treating doctors and the administrative complexity of the system play an important role in setting appropriate rates and assuring adequate access to health care providers. In establishing the rate included in the Medical Fee Guideline, the Labor Code requires the Division to consider many factors. The disability management rules, as well as other Division rules, will play a significant role in future revisions to designated doctor reimbursement. IRO fees are set by Department of Insurance rules Chapter 12, Subchapter E, §§12.401, 12.402, and 12.403, and are outside the authority of the Division and these disability management rules.

General: Commenter states that although citing Labor Code §413.021 as an effective statutory provision, the rules do not implement the provisions of §413.021(e) requiring the Division to adopt rules necessary to collect data on return to work outcomes to allow full evaluation to success and barriers to achieving timely return to work after an injury.

Agency Response: The Division agrees that these rules do not include a specific data collection component. The adoption of these rules, however, sets benchmarks for potential use in evaluation of various components of the workers' compensation system.

General: Commenters observe the proposal preamble states ODG covers 99% of conditions, but this does not mean ODG covers 99% of services delivered.

Agency Response: The Division agrees.

General: Commenter suggests the Division begin immediately working on either a pharmacy formulary or treatment protocol for pharmaceuticals, particularly narcotics.

Agency Response: The Division acknowledges the commenters' recommendation and is currently in the initial phase of rule making to develop a closed formulary. Additionally, the Division notes that ODG has begun to add pharmaceutical information to the treatment guideline.

General: Commenters recommend clarification between the appropriate usages of the two guidelines. The proposal preamble leaves the impression that the return to work guidelines may be used to identify medical care to be delivered, which should be the function of the treatment guidelines.

Agency Response: The Division agrees. The language is changed in §137.10 and §137.100 to clarify the use of the adopted guidelines.

General: Commenter supports the disability management concept. A commenter supports the combination of MDA and ODG guidelines since both provide an excellent evidence-based and useable system for benchmarking purposes in the Texas workers' compensation system. Commenter states this combination provides the highest level of well-documented, up-to-date, unbiased, and usable evidence-based guidelines for system use. Commenter states the rules provide enhanced communication between system participants at the ultimate benefit of assuring that the injured employees of Texas receive prompt and appropriate health care.

Agency Response: The Division agrees with commenter's assessment of the disability management concept.

General: Commenters support the disability management system outlined in the proposed rules as resulting in increased communication among system participants and improved return to work outcomes for injured employees. A commenter further sup-

ports the emphasis of evidence-based guidelines, as outcomes for all system participants can be optimized.

Agency Response: The Division appreciates the supportive comments.

General: Commenter states these rules are designed to favor and increase the balance of power toward the insurance carrier, to the unreasonable detriment of the injured employee. Commenter also states that it is unfair to infer that injured employees are less motivated to get better or return to work when claims are carefully researched, it will be noted that there are systematic denials of necessary treatment. There is also systematic lack of cooperation on behalf of employers to provide work within the work restrictions by the treating doctor.

Agency Response: The Division disagrees. The disability management concept and rules are designed to provide a framework to enhance treatment and return to work outcomes for injured employees. The tools establish benchmarks to facilitate communication between system participants and formulate return to work plans. The benchmarks establish starting points, which may be adjusted based on the specific circumstances of the claim.

General: Commenter states both return to work and treatment guidelines should be used only as guidelines and benchmarks, and not as a monitor for health care accuracy of reasonable and necessary treatments. All parties, insurance carriers, injured employees, the Division, IROs, designated doctors, required medical examinations, peer reviewers, and preauthorization, should be required and allowed to substantiate when a treatment or disability exceeds or reduces the recommendations in the guideline for that specific injury.

Agency Response: The Division agrees that the adopted guidelines establish benchmarks for use in the system. The Division anticipates that health care providers and insurance carriers will integrate the disability management concept to assure effective and efficient health care and promote early and appropriate return to work for injured employees. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7. Individual claims may require more or less treatment or more or less recovery time based on the specifics of the injury. It is the intent of the Division that a variance from the guidelines should be supported by documentation.

General: Commenter states to require use of these guidelines is excessive management, creates new costs, adds new barriers to creating a workable environment for quality health care and will not be an incentive to bring quality health care providers into the system. Parts of these rules contradict root causes for the passage of HB 7. Agency Response: The Division disagrees. Uncertainty of expectations leads to confusion and frustration for all system participants. Disability management rules provide guidelines that create reasonable expectations about the operation of the workers' compensation system. These benchmarks lead to consistency and more certainty for all stakeholders.

General: Commenter is discouraged that anyone could be convinced that the new workers' compensation system is improving the way injured employees are taken care of in Texas and provides anecdotal examples of this concern.

Agency Response: Commenter's concerns are noted, however, commenter's concerns are not related to the adopted sections.

General: Commenter is in receipt of stakeholder comments recommending treatment protocols for pharmaceuticals and narcotics. Commenter indicates ODG addresses the various pharmaceuticals and summarizes the medical evidence and the resulting recommendations. In particular, there is detailed information on opioids and other narcotics in the Chronic Pain Section, which include definitive patient selection criteria to be used by medical providers.

Agency Response: The Division acknowledges the Chronic Pain Section of the ODG.

General: Commenter notes that HB 7 indemnifies the insurance carrier for any aggravation or worsening of symptoms ascribed to any delay of treatment brought on by the insurance carrier's officious behavior. Commenter states that the rules permit penalizing physicians who bill their usual and customary fees rather than billing the amount specified by the medical fee guidelines. Commenter also notes that the proposed rules will repel physicians from entering into the system.

Agency Response: The Division acknowledges the commenter's concern regarding HB 7 and disagrees the rules penalize physicians who bill their usual and customary fees. Fee and reimbursement topics are generally outside the scope of these rules. The Division disagrees the adopted rules will deter physicians from the workers' compensation system. The Division believes adoption and implementation of the disability management concept and associated rules will increase communication opportunities for system participants, bring structure and certainty to the process, and ultimately decrease administrative burdens for system participants.

§137.1: Commenter recommends that the Division consider in its Performance Based Oversight initiative, the doctors who consistently do not follow the treatment guidelines, or are consistent outliers of the treatment guidelines.

Agency Response: The Division is developing standards relating to Performance Based Oversight through a process that includes stakeholders. The language in §137.1 is permissive and allows the use of treatment and return to work guidelines throughout the Division's programs. The Performance Based Oversight initiative is best suited to develop an integration of the guidelines into the evaluation standards.

§137.1(a): Commenter questions whether the proposed rules apply to every claimant, or only when there is a finding that the injured employee is at risk for delayed recovery.

Agency Response: The Division clarifies that the disability management philosophy applies to all injured employees not subject to a certified workers' compensation network. Because the proposed term *at risk* was not clear, it is deleted in subsection (a). The phrase *to avoid delayed recovery* is substituted as it indicates that avoiding delayed recovery is appropriate for any injured employee.

§137.1(a): Commenter recommends adding standards to the rule for making determinations as to which employees are at risk for a delayed recovery. The Division should identify the decision maker of an injured employee's at risk status. Commenter further recommends the Division develop training and testing for doctors to demonstrate medical expertise in determining at risk status. Commenter states that without at risk standards the determination would be a subjective assessment that has the ability to undermine the disability management process.

Agency Response: The Division agrees that there is confusion regarding the term "at risk." With the deletion of this term, there is no need to define or identify the criteria for being "at risk." All injured employees are included in the disability management concept in order to avoid delayed recovery.

§137.1(b): Commenters recommend the term "shall" be used in place of "may" to clarify that the Division will use the tools for all of the stated purposes. Commenters question the propriety and effectiveness of achieving better return to work and medical outcomes if the use of the guidelines by the Division remains permissive and not mandatory. One commenter states that if the Division renders a decision or takes an administrative action contrary to its guidelines, then the Division should explain, in writing, the facts that justify the Division's deviation from its guidelines.

Agency Response: The Division declines to make this change. Adopted subsection (b) pertains to the integration of these tools by the Division throughout all of its processes and, as such, regulatory language is not required here. The Division will consistently apply the criteria in this subsection, but will maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

§137.1(b) and (d): Commenter states the guidelines should not be used to grade or assess the quality of any practitioner.

Agency Response: The Division disagrees that the guidelines require the grading or assessing of quality of a particular health care provider. However, Division activities relating to quality and performance may integrate standards including the benchmarks established by guidelines into the evaluation process of system participants.

§137.1(d): Commenter states the treatment guidelines should not be considered to carry presumptive weight in any decision of denial or recommended treatments.

Agency Response: The Division disagrees that treatment guidelines should not carry presumptive weight since it would be contrary to the provisions of §413.017(1) and §413.011(e) of the Labor Code and would impede implementation of HB 7.

§137.1(d): Commenter suggests defining "scientific medical evidence" or otherwise a doctor may submit scientific medical evidence only to have the insurance carrier say it is not, which would not allow any variance from the guidelines.

Agency Response: The Division agrees that the use of "scientific medical evidence" is confusing or could lead to confusion between insurance carriers and health care providers. Consequently, the language has been deleted.

§137.1(d): Commenter supports this provision as written. The provision establishes the importance of medical policies for the workers' compensation system and should not be overridden by IRO decisions, which are made on a case-by-case basis.

Agency Response: The Division agrees.

§137.1(d): Commenters urge the Division to retain proposed rule language of §133.308(n)(1)(G) that requires the IRO to explain the specific basis for recommending treatment as that proposed rule relates to this subsection. To avoid confusion, commenters recommend duplicating language in proposed §133.308(n)(1)(G) that requires an IRO decision that is contrary to adopted treatment guidelines or protocols to provide the specific basis for the variance. Another commenter recommends rule inclusion that should the IRO determine a variance from the treatment guidelines, the IRO must reference scientifically based medical evidence, or the lack of efficacy of similar treatment previously provided to the claimant to support any variance from a treatment guideline, to include the lack of efficacy of similar treatment as previously provided to the claimant.

Agency Response: The Division agrees that the IRO decisions should be fully explained and documented in accordance with applicable IRO rules. However, the Division disagrees that additional references to the IRO process are required in this section.

§137.1(d): Commenters state that while a medical necessity IRO decision may take precedence over adopted treatment guidelines, it would be incongruent with the presumption created by the statute as to the treatment guidelines to allow an IRO to simply ignore the treatment guidelines, or to know which citations are credible.

Agency Response: The Division agrees that Labor Code §413.017 provides that Commissioner adopted medical policies are presumed reasonable. However, these adopted sections do not provide for an IRO to ignore treatment guidelines and Division §133.308 establishes the criteria for an IRO decision that deviates from Division policies or guidelines.

§137.1(d): Commenter recommends added language to read, "In a medical necessity dispute, insurance carriers, health care providers and injured employees should submit scientific medical evidence 'based on appropriately peer-reviewed, double-blinded and fully vetted data' that establishes that a variance from the adopted treatment guidelines or treatment protocols is reasonably required to cure and/or relieve the injured employee from the effects of the compensable injury." The commenter states this would further define "scientific medical evidence" and answer the questions as to which citations are credible and who determines the veracity of the citations. Commenter further states this would assist a non-medically trained hearing officer to ensure the highest and most prevailing standard of care.

Agency Response: The Division disagrees that the recommended language to define scientific medical evidence is necessary. Language regarding requirements of documentation to be submitted in a medical necessity dispute has been deleted because this criterion would be duplicative of the requirements of §133.308 and would also be confusing.

§137.1(d): Commenter recommends changing the term "should" to "shall" so that the rule reads, "In a medical necessity dispute, insurance carriers, health care providers and injured employees 'shall' submit scientific evidence that establishes..." Commenter further recommends that subsection (d) be revised, written in plain language so that the case-by-case basis is made clearer.

Agency Response: The Division disagrees with commenter's recommended language substitution or need for revision. This language in the subsection has been deleted because the specific requirements of the IRO process are included in §133.308 and such language is confusing and is not necessary in this section.

§137.10: Commenter believes the addition of a case management function is missing, but necessary in this rule proposal. Commenter recommends the payor reimburse the doctor for this case management function, which would include employer contacts and negotiated stay-at-work/return-to-work plans.

Agency Response: The Division disagrees that the basic form of medical case management is not addressed as the Division notes this is the role of the treating doctor in the workers' com-

pensation system. These rules enhance the ability of the treating doctor to fulfill the requirements of §408.025 and §408.021 of the Labor Code by requiring increased communication between referral providers and the treating doctor for claims requiring treatment planning. The coordination of that comprehensive plan is the responsibility of the treating doctor. The Division acknowledges that case management services referred to in §413.021 of the Labor Code have not yet been proposed. The Division intends future rule-making activities to address this form of case management services as well as other components of the disability management chapters and rules. Case management activities are currently addressed in §134.202, however, adjustments to the Medical Fee Guideline may be required as disability management concepts are fully integrated into the workers' compensation system.

§137.10: Commenter states stakeholders should be equally accountable for the employees' return to work and encourages the Division to consider educating employers about their responsibilities for accepting injured employees back to work.

Agency Response: The Division agrees that all system participants have a responsibility to encourage and facilitate return to work. The Division provides focused educational efforts with employers emphasizing return to work through seminars, publications, and website information. The Division believes these rules provide tools to enhance the exchange of information between system participants to develop more effective return to work plans and improve return to work outcomes.

§137.10(a): Commenter supports the adoption of the MDA Guidelines for the following reasons: MDA is accepted globally as an industry standard; MDA guidelines are scientifically valid and evidence based; MDA uses the best available external evidence based on 5 million records of observed data by those managing the injury or illness and/or paying the claim; MDA guidelines dramatically reduce lost time days; MDA creates a mechanism for communication between health care providers and patients whereby everyone starts on the same page; MDA sets recovery expectations for patients and gives health care providers a framework for counseling and guiding patients regarding return to work expectations; and MDA uses the best available external evidence based on 5 million records of observed data by those managing the injury or illness and/or paying the claim. Another commenter supports adoption of the MDA return to work guidelines even though not everything will require the values noted, and some issues will require more.

Agency Response: The Division appreciates the support of the MDA as the Division's return to work guidelines.

§137.10(a): Commenter states the rule seems to mandate the use of return to work guidelines when it is or could be detrimental toward the claimant; however, the guidelines are optional when they could be detrimental toward the insurance carrier.

Agency Response: The Division disagrees that the return to work guidelines are biased against a claimant or optional for insurance carriers. The guidelines are benchmarks to facilitate communication between system participants and formulate return to work plans. The benchmarks establish starting points, which may be adjusted based on the specific circumstances of the claim.

§137.10(a): Commenter believes MDA, as a return to work guideline, is not designed to reduce excessive or inappropriate medical care.

Agency Response: The Division agrees that the return to work guidelines are not directly designed to reduce excessive or inappropriate medical care. However, early and appropriate return to work directly impacts the need for, and types of, medical care provided to injured employees. Ultimately, this early intervention impacts system costs.

§137.10(a): Commenter is concerned that MDA does not take into consideration the complexity of the job and the job specific requirements for return to work. Commenter states this will cause a huge problem in outcomes if the insurance carriers deny treatment without considering all of the factors involved in the injury, diagnosis, as well as the complexity of the job and the requirements for return to work.

Agency Response: The Division disagrees. Although not every circumstance of a particular job is included in the MDA, broad categories related to the intensity of a job activity are included. As previously stated, these guidelines are a tool to develop return to work plans and set benchmarks. They provide the foundation for implementation of §413.021(b) of the Labor Code, which include job analysis, job modification and restructuring assessments.

§137.10(a): Commenter opines that the rules significantly impinge on the ability of health care providers to treat those injured employees who do not improve on the arbitrary, rigid schedule.

Agency Response: The Division disagrees. Medical care provided in the workers' compensation system is still controlled by the basic premise of an injured employee's entitlement to certain benefits, including medical benefits. These rules facilitate treatment planning and return to work planning and allow for development of those plans based on the injured employee's specific situation and medical needs.

§137.10(a): Commenters recommend the Division be required to apply the return to work guidelines and question the propriety and effectiveness of achieving better return to work and medical outcomes if the Division's use of the return to work guidelines remains permissive and not mandatory. A commenter recommends the rules should create a presumption in favor of the disability guidelines adopted and any decision by a hearing officer or the Appeal Panels that is at variance with the disability guidelines should be explained as to why such variance is appropriate in the particular case. Additionally, interlocutory orders should not be issued for payment of temporary income benefits (TIBS) in a case where the requested disability is inconsistent with the disability guidelines

Agency Response: The Division declines to make these changes because it is inconsistent with Division policy. Division policy is that guidelines are intended to develop benchmarks for treatment while also considering the specific situations and medical needs of injured employees. Adopted subsection (a) pertains to the use of MDA by system participants, and as such, prescriptive language for the Division is not required. The Division will consistently apply the criteria in this subsection, but will maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions. The Division notes the section permits system participants and the Division to consider an injured employee's co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when establishing return to work goals or revising expected return to work durations and goals. Disability durations in the guidelines are not absolute

values and do not represent specific periods of time at which an injured employee must return to work; instead, the values represent points in time at which additional evaluation may occur if an injured employee has not experienced a full medical recovery and returned to work. Therefore, the suspension of an injured employee's TIBS is not mandatory if the injured employee's disability duration is inconsistent with the return to work guidelines.

§137.10(a): Commenter recommends identifying triggers in the return to work guidelines to initiate the requirement for treatment planning such as ODG's "at risk" date, which is suitable for this purpose. Commenter further opines that MDA's optimum number of days will result in well over 50% of cases being forced into treatment planning.

Agency Response: Because the term *"at risk"* in proposed §137.1(a) is not clear, it is deleted and the phrase *"to avoid delayed recovery"* is substituted as it indicates that avoiding delayed recovery is appropriate for any injured employee. The use of a return to work guideline as a trigger for treatment planning is not addressed in §137.10, but is addressed in adopted §137.300. Treatment durations and other considerations outlined in §137.300 clarify the requirements for treatment planning. Since duration is not the only consideration in the treatment planning process, it is unlikely that 50% of the cases will require treatment planning.

§137.10(a): Commenter outlines the differences in the sources of data used to develop MDA and ODG return to work guidelines. Commenter states that by adopting MDA the state of Texas can rest assured it is working with the best evidence-based return-to-work guideline available.

Agency Response: The Division appreciates the support of the Division's selection of MDA as the Division's return to work guidelines.

§137.10(b): Commenter recommends clarifying language including that the rule does not apply to claims subject to workers' compensation under health care networks under Chapter 1305 of the Insurance Code.

Agency Response: The Division acknowledges the commenter's concern regarding the applicability of the adopted disability management rules to health care networks, however, the Division declines to make the modifications to the rule that reiterates the provisions of HB 7 and the sections of the Labor and Insurance Codes. Labor Code, §413.011(g) provides that rules adopted relating to disability management do not apply to claims subject to workers' compensation networks. Workers compensation networks are required to adopt their own treatment guidelines, return-to work guidelines, and individual treatment protocols, pursuant to Insurance Code, §1305.304. Based on the specificity of the Labor Code and Insurance Code provisions, it is the Division's opinion that it is unnecessary to restate such provisions in the adopted rules.

§137.10(b): Commenter recommends that if the Division adopts two separate guidelines as proposed, one for return to work and one for treatment guidelines, further clarification should be made that treatment information in the MDA should not be used by system participants.

Agency Response: The Division agrees. Language is added to §137.10 and §137.100 to clarify the use of the adopted guidelines.

§137.10(c): Commenter recommends using "optimum" time frames as provided in MDA for each specific diagnosis and job description; and, commenters recommend adding language, "optimum disability duration identified in the..." or "maximum duration and job classification clarification". Commenter states it is more reasonable for all system participants to adopt the "optimum" disability duration as the statistical norm (benchmark), rather than assuming that disability will reach the accepted "maximum" in all situations.

Agency Response: The Division disagrees with the use of the MDA "optimum" time frames as a disability duration benchmark as the return to work standard for each specific diagnosis and job description, and thus disagrees with suggested language addition. While the disability duration tables provide benchmark information on expected lengths of disability, the values do not represent the absolute minimum or maximum lengths of disability at which an individual must or should return to work. Rather, they represent important points in time at which, if full recovery has not occurred, additional evaluation should take place. These values are designed to allow individual differences in recovery time based on the numerous variables that impact disability duration. System participants should consider many factors including the diagnosis, any age-related complications, medications, return to work facilitations, availability of modified, alternate or transitional duty, job duty demands, managed disability programs, and employer's workplace factors when evaluating readiness for return to work.

§137.10(c): Commenter suggests defining "reasonable." Commenter states that this provision requires that the guidelines shall be presumed reasonable. Commenter questions the standard for overturning this presumption. Commenter further inquires whether the presumption disappears or shifts upon a showing to the contrary.

Agency Response: The Division disagrees with commenters' recommendation to further define "reasonable." In establishing the guidelines, the Reed Group collected data on more than 3.5 million workplace absence cases from multinational companies and governmental organizations to compile the normative database for the Fourth Edition. The database consists of actual workplace absence data from a wide range of industries and geographic locations. In order to represent the most objective, accurate, and reliable view of disability duration, Reed Group's data set includes organizations that manage disability as well as those without case management services. The Division clarifies that a "standard for overturning the presumption of reasonableness" is not necessary in this rule since the disability durations are not absolutes or an end in themselves. The disability durations are benchmarks for establishing or re-assessing goals, or are the basis for a designated doctor examination, case management or a referral to vocational rehabilitation. These values do not represent the minimum or maximum lengths of disability at which an individual must or should return to work. Rather, if full recovery has not occurred, they represent important points in time that may indicate that further evaluation and planning is appropriate. The values are designed to allow individual differences in recovery time based on the numerous variables that impact functional restoration, and as such should be used as a communication tool for the insurance carrier, health care provider, injured employee and employer to discuss the patient's progress or any need to extend the established values.

§137.10(c): Commenter supports the Division's adoption of the MDA as a guideline for providing disability duration expectan-

cies. Commenter recommends a rule requirement that a health care provider submit supporting documentation when a return to work goal for an injured employee differs from the MDA chart estimation for the employee's particular injury. Commenter further recommends that the rule require that the health care provider identify the basis for a determination of job classification, i.e., employee, employer, or job analysis. Commenter believes that an employee's estimation of the kind of work the employee performs is not, in fact, always what is documented in the employer's job analysis. These recommendations are necessary since the MDA guidelines are not "absolute values" and do not address how to calculate a co-morbid or complicating factor's impact on the expected duration of a disability, and a standard calculation cannot be applied.

Agency Response: The Division declines to make the modifications to the rule for reasons previously stated that not every circumstance of a particular job is included in the MDA, and broad categories related to the intensity of a job activity are included. These guidelines are a tool to develop return to work plans and set benchmarks. They provide the foundation for implementation of §413.021(b) of the Labor Code, which includes job analysis, job modification and restructuring assessments.

§137.10(c)(2): Commenters state the rules are silent and fail to specify consideration of the guidelines by designated doctors, benefit review officers and hearing officers when determining disputes of return to work disability length issues, which may result in confusion. The insurance carrier's use of the return to work guidelines is unnecessarily and inappropriately limited to a basis of requesting a designated doctor appointment, or referral to rehabilitation, regardless of prior findings on those same appointments or referrals. This renders any presumption moot. Though proposed §137.1(b) specifically permits the Division to use Chapter 137 rules as tools in income benefit disputes, the specificity of §137.10(c) fosters potential conflict. Commenters recommend requiring the designated doctor to presume that the Division's return to work guidelines provide a reasonable length of disability duration, and if the designated doctor finds disability beyond the period of time outlined in the guidelines, then the designated doctor should identify the medical facts that justify a longer duration of disability; or, offer scientific medical evidence that establishes a variance. Commenter recommends the presumption of some other evidence, such as treatment guidelines, be considered when ascertaining whether a designated doctor's report on MMI is entitled to presumptive weight when the two are in conflict. Commenters recommend that the Division should be required to presume that its guidelines provide a reasonable length of disability duration and should be used by the Division in resolving disputes. Further, if the Division resolves a disability dispute by finding that the employee is entitled to temporary or supplemental income benefits for a time in excess of the expected length of disability duration, then the Division should explain how the facts of the claim justify a greater period of lost time. A commenter states the designated doctor should be required to presume that the return to work guidelines provide reasonable length of disability duration, and if the designated doctor finds disability beyond the period of time outlined in the guidelines, then the designated doctor should identify the medical facts that justify a longer duration of disability. Commenter recommends that if a designated doctor increases or lessens an injured employee's return to work period he should specify his reasoning.

Agency Response: The Division disagrees that the provisions of subsection (c)(2) restrict the insurance carrier's use of the guidelines. The overarching disability management concept anticipates the use of MDA as a benchmark, and not an absolute, to facilitate return to work planning and ultimately improve return to work outcomes. Further, commenters are directed to subsection (e) of this section, which provides flexibility for the application of the guidelines to a particular injury. The Division agrees that the designated doctor decisions should be fully explained and documented in accordance with rules pertaining to the roles and function of designated doctors. However, it is the Division's opinion that no additional references to the designated doctor responsibilities are required in this section.

§137.10(c): Commenter recommends new paragraphs (4) and (5) be added to this subjection that identify how the Division intends to use the return to work guidelines: "(4) Division Medical Advisor and Medical Quality Review Panel in order to review performance of doctors on the Approved Doctor's List and other health care providers; and (5) Division Contested Case Hearing Officers and Appeals Panel in deciding benefit disputes involving issues of existence and duration of disability."

Agency Response: The Division declines to make the recommended additions since the requested provisions are already included with the use of disability management tools as outlined in §137.1(b). The Division policy is to consistently apply the disability management tools, and to also maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

§137.10(d): Commenter states it is improper to claim that co-morbidity may be considered; instead, co-morbidity must be considered. Agency Response: The Division declines to make a change, as co-morbidities will not always be present in each individual case. However, the Division clarifies that system participants should consider all factors including any applicable co-morbidity, diagnosis, any age-related complications, medications, return to work facilitations, availability of modified, alternate or transitional duty, job duty demands, managed disability programs, and employer's workplace factors when evaluating readiness for return to work.

§137.10(d): Commenter supports language in the subsection and states in real life patients often present with multiple diagnoses, which complicates their treatment and may extend their disability. This fact needs to be taken into account and explicit reference in the rule is a good idea.

Agency Response: The Division appreciates the supportive comment related to subsection (d).

§137.10(d): Commenters recommend clarifying "other factors" as the term is vague, undefined (e.g., not just subjective complaints of pain) and subject to variance in interpretations and applications. Commenter recommends that other factors considered should specifically include objective, documented medical findings of sufficient quality to overcome the return to work guidelines' presumption of reasonableness.

Agency Response: The Division declines to further define factors that system participants may need to consider as mitigating circumstances when setting return to work goals or revising expected return to work durations and goals. Specificity in this area could potentially hinder communication efforts and limit the ability to fully consider and implement a return to work plan.

§137.10(d): Commenter recommends deletion of subsection (d) because the presence of co-morbid conditions are already ad-

dressed in the return to work guidelines, and there is no need to specifically account for such conditions in the rule.

Agency Response: The Division acknowledges that although co-morbidities are already addressed in the guidelines, there may be situations where consideration of other, unlisted co-morbidities may be appropriate. Failure to identify and consider those co-morbidities could lead to a delayed recovery, which is contrary of the expressed purpose of the disability management concept as provided in §137.1(a).

§137.10(e): Commenter suggests MDA guidelines be used in the context of the users' experience and judgment, and should not be used to tell the doctor what to do or not do. No injured employee should be denied payment based on the guidelines.

Agency Response: The Division agrees that the guidelines are a tool to be used to enhance the knowledge of system participants concerning return to work time frames. Return to work planning should integrate the disability management tools as well as the experience and judgment of the system participants. The Division also agrees with commenter that return to work guidelines should not be the sole justification for granting or denying income benefits to an injured employee. Subsection (e) has been changed to further clarify this provision.

§137.10(e): Commenters support the provisions of subsection (e) and especially referencing that the insurance carrier may not use the guidelines to reduce or deny income benefits. Commenter recommends adding the phrase "health care benefits." Another commenter supports this provision that prevents the return to work guidelines from being used as a justification to reduce or deny injured employees' income benefits.

Agency Response: The Division clarifies subsection (e) is changed to indicate that Division return to work guidelines should not be used as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. The Division declines to add the recommended language because the MDA does not address medical care.

§137.10(e): Commenters recommend that while the rule could state that an insurance carrier may not use the guidelines as the sole (emphasis added) basis for suspension or refusal to initiate benefits, the rule should favor claim management decisions that are based upon guidelines that the Division specifically states are scientifically based.

Agency Response: The Division will consistently apply the criteria in this subsection, but will maintain its independent duty to provide for exceptions as needed in order to accomplish the intent of HB 7 and other statutory provisions.

§137.10(e): Commenter justifies that to preclude the insurance carrier from considering the adopted disability guidelines in assessing the doctor's credibility as to disability, is to limit the range of evidence in a manner inconsistent with articulated legislative intent. Commenter further suggested that the insurance carrier should be able to refuse to initiate, or suspend, benefits on the basis of disability guidelines. If the claimant disagrees, as proving disability is the claimant's burden, the claimant can request a designated doctor to address the issue. Another commenter asserts it is proper for the insurance carrier and the Division to consider the guidelines as a useful tool in deciding if existing medical opinions and claim investigation support the ongoing disability.

Agency Response: As previously stated, the Division clarifies that designated doctors, IROs and other hearing officers' decisions should be fully explained and documented in accordance with rules pertaining to their roles and functions in the workers' compensation system. However, it is the Division's opinion that no additional reference is required in this section. The Division agrees that the adopted return to work guidelines are a valid benchmark in assessing an injured employee's ability to return to work. However, language was added to this subsection to clarify that an insurance carrier may not use the return to work guidelines as the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee.

§137.10(e): Commenter recommends that the rule should specify that benefit reductions or denials should not be based solely on the return to work guidelines, as there is no statutory prohibition to consider the return to work guidelines in making benefit determinations. Commenter further opines the limitations placed on return to work guidelines usage appear to be in conflict with §413.011(f) of the Labor Code.

Agency Response: The Division agrees and subsection (e) is changed to clarify that return to work guidelines should not be the sole justification or the only reasonable grounds for reducing, denying, suspending, or terminating income benefits to an injured employee. The Division disagrees that the limitations related to the use of the guidelines for denial of benefits conflicts in any way with §413.011(f) of the Labor Code. Subsection (e) allows the use of the guidelines to deny benefits, but prevents their use as an arbitrary standard without consideration of other factors.

§137.10(e): Commenters support and agree that the MDA published by the Reed Group is based on statistical analysis of actual outcome data and return to work outcomes for workers' compensation should fall in line with that summary.

Agency Response: The Division appreciates the supportive comment related to subsection (e).

§137.10(f) Commenter recommends alternate language that substitutes "may" for "shall," because commenter states it would be impossible for system participants to be able to comply with the mandatory requirements of this rule since at the present time there does not exist evidence-based medicine that addresses disability duration parameters and return to work goals for all diagnoses or injuries that are not addressed by the MDA.

Agency Response: The Division declines to make the recommended change, but recognizes that as proposed, system participants may not be able to fully comply with the requirements. The language is changed to clarify that in instances not addressed by the Division return to work guidelines, the principles of evidence-based medicine are to be applied to establish return to work goals.

§137.100: Commenter states that litigation is pending against the WLDI in federal court. Commenter provides documentation of the complaint and states that the plaintiff alleges breach of contract in connection with a royalty agreement, breach of a confidentiality agreement, and conversion of confidential business information. Commenter takes no position on the merits.

Agency Response: Based on the documentation provided by the commenter, the Division disagrees that the complaint against WLDI is relevant to the disability management rules. The thrust of the allegations concerns a contract dispute not relevant to the disability management rules adopted by the Division.

§137.100: Commenter supports the concept of treatment guidelines and treatment planning as they are the focus of these proposed rules for workers' compensation reform. Commenter states that the appropriate use of the treatment guidelines is more important than which treatment guidelines are adopted. When used appropriately, treatment guidelines can be an effective tool to control utilization and inappropriate health care.

Agency Response: The Division appreciates the supportive comments pertaining to treatment guidelines and treatment planning.

§137.100: Commenter states agreement with the Federal Aviation Committee's conclusion that evidence-based medicine, selected or implemented without clinical experience, is very dangerous.

Agency Response: The Division agrees that clinical expertise is an important consideration in the effective application of treatment guidelines. The Division anticipates health care providers in the Texas workers' compensation system will integrate their expertise with the adopted treatment guidelines so that effective and efficient medical care is provided to injured employees in order to improve return to work outcomes.

§137.100: Commenter states that the proposed rule is significantly better than the pre-proposal rule that provided an unrebuttable presumption that all treatment in the treatment guidelines is reasonable and necessary without regard to the particular facts of the individual case.

Agency Response: The Division appreciates the comment and acknowledges the change was made from pre-proposal drafts as a result of system stakeholders' input.

§137.100: Commenter states that monthly or quarterly updates sound appealing, but is inconsistent with evidence-based medicine. Continuously updated guidelines present a moving target for treating physicians and reviewers, requiring continuous retraining and inefficiency. Commenter opines that the literature seldom produces an article so compelling that it alters an evidence-based guideline. Commenter states that it takes a number of studies carried out in different settings by different investigators to convince guideline developers that a finding is valid.

Agency Response: The Division disagrees that the continual updating of treatment guidelines is inconsistent with evidence-based medicine. Labor Code, §401.011(18-a) contemplates the use of *current* scientific and medical evidence to assist health care providers in making decisions about the care of employees with work-related injuries by defining "evidence-based medicine" to mean "the use of *current* best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients." One resource reports that "without current best evidence, a clinical practice risks becoming rapidly out of date, to the detriment of patients." David L. Sackett, William M.C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, and W. Scott Richardson, *Evidence Based Medicine: What It Is and What It Isn't,* British Medical Journal 312 (7023), 13 January, 71-72 (1996). Another reference provides that regular updating of reviews is necessary in order to ensure the accuracy of the information since "a print review article is out of date as soon as it is published." Lisa A. Bero, Ph.D, *Evaluating Systematic Reviews and Meta-Analyses,* Journal of Law and Policy 570, 578 (2006). Based on the findings of new studies as they are released, the Division believes it is appropriate for WLDI to review the ODG treatment guidelines and make necessary revisions due to its frequent review of the scientific medical literature, survey data analysis, and expert panel validation.

§137.100: Commenters express concern regarding ODG's disclaimer language that states the treatment guidelines are not to be used as cookbook medicine for rendering medical advice, and the final opinion regarding treatment and the ability of a patient to return to work rests with the physician treating the patient. Another commenter states that ODG does not consider the complexity of the job, job requirements for return to work, or other medical problems that may effect healing and/or complications related to the diagnosis/injury. It is very important that all of these things must be considered in a treatment guideline.

Agency Response: The Division notes commenters' concerns. The Division anticipates health care providers' ability to use these tools, and the treatment guidelines as a framework to develop treatment for injured employees. The health care provider must consider care above or below the guidelines consistent with the unique factors associated with an injury. The rules anticipate certain care outside or inconsistent with the treatment guidelines be managed through treatment planning as coordinated with the preauthorization process.

§137.100: Commenter is concerned that insurance carriers and peer review doctors will utilize the synopsis of the outline for care without utilizing the entire ODG guidelines, which only benefits the payors.

Agency Response: The Division notes the commenter's concern. Injured employees continue to be entitled to all health care reasonably required by the nature of their compensable injury when necessary as established by Labor Code §408.021. Section 137.100(a) provides that health care providers shall provide treatment in accordance with the current edition of ODG unless the treatment(s) or service(s) require preauthorization in accordance with §134.600 or §137.300. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100: Commenters state that the Federal Agency for Healthcare Research and Quality (AHRQ) does not investigate the evidence-based credibility of guidelines accepted for inclusion in the National Guideline Clearinghouse. Another Commenter provides that AHRQ does not permit guideline listing to be used for promotional purposes.

Agency Response: The Division agrees that AHRQ does not review information contained in an individual guideline's content. However, the intent of the National Guideline Clearinghouse is to make evidence-based clinical practice guidelines available to health care professionals after meeting the criteria for inclusion. The Division acknowledges that inclusion of a guideline in the National Guideline Clearinghouse does not constitute an endorsement by AHRQ or any of its contractors of the guideline. The Division does not agree that a guideline included in the National Guideline Clearinghouse is prohibited from disclosing its inclusion in the database and providing the criteria for inclusion.

§137.100: Commenter recommends spine injuries be addressed separately. Commenter additionally recommends a separate law that incorporates American Association of Orthopedic Surgeons (AAOS) and North American Spine Society (NASS) algorithms for spine injury and includes updates of those algorithms.

Agency Response: The Division declines to develop rules that separately address spinal injuries and believes the ODG sufficiently addresses spinal injuries. The disability management concept provides for the treatment of spinal injuries through the references provided in the treatment guidelines, treatment planning and preauthorization. The Division clarifies that amendments to the Labor Code would need to occur through the legislative process and not through the agency's rule making authority.

§137.100: Commenter's opinion is that ODG treatment guidelines fail to take into consideration the full complexities of the spine and ODG provides overly simplistic recommendations that fail to recognize the multiple factors involved in the extensive decision-making process prior to performing spinal surgery.

Agency Response: The Division believes the ODG sufficiently addresses spinal injuries. The Division agrees that identifying and recommending appropriate treatment can involve a complex decision making process. Prior to any spinal surgery, the ODG should be followed. If spinal surgery is medically necessary, then preauthorization must be obtained before the service is provided, as required by Labor Code §413.014. Preauthorization for spinal surgery is required whether the care is in accordance with or outside the treatment guidelines.

§137.100: Commenter states that there is potential that patients may be denied the necessary and appropriate care based on the guidelines alone, and not the accepted treatment standards that carry a greater degree of validity and scientific merit than a guideline.

Agency Response: The Division notes the commenter's concern. Injured employees continue to be entitled to all necessary health care as established by Labor Code §408.021. The Division anticipates that health care providers and insurance carriers will integrate the disability management concepts to assure effective and efficient health care and promote early and appropriate return to work for injured employees. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100 Commenter recommends the Division not adopt the ODG treatment guidelines in their current form, as further up-to-date work is needed by ODG that recognizes already proven treatment methodologies.

Agency Response: The Division disagrees. The Labor Code requires the Commissioner to adopt treatment guidelines for use in the workers' compensation system. The ODG is the best match for the system at this time. ODG reviews new information and studies as they become available and integrates these references into the online version on an ongoing basis. Additionally, a health care provider may submit treatments and services not included in the adopted treatment guidelines for preauthorization by the insurance carrier.

§137.100: Commenter states this rule is an inflexible restraint on the patient's ability to receive appropriate care and it ignores the uniqueness of each patient, co-morbid conditions, medical complications or other factors. Commenter states this rule envisions cookie-cutter treatment for all injured employees regardless of their individual abilities to recover or return to work.

Agency Response: The Division disagrees. The Division anticipates health care providers' ability to use these tools, and the treatment guidelines as a framework to develop treatment for injured employees. The health care provider must consider care above or below the guidelines consistent with the unique factors associated with an injury. The rules anticipate certain care outside or inconsistent with the treatment guidelines be managed through treatment planning as coordinated through the preauthorization process. Injured employees continue to be entitled to all necessary health care as established by Labor Code §408.021. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100: Commenter states that adoption of ODG will not reduce excessive or inappropriate medical care and provides examples to support this position. Commenter opines that if the "Codes for Automated Approval" are used as presented without instruction for appropriate use, surgeries (for example, for carpal tunnel syndrome and discectomy), multiple imaging studies, and levels of service in excess of those proven effective would be automatically approved. Commenter believes such automated approval would render the utilization review process inoperative to a large extent and would mandate approvals without consideration of individual case information, as would occur when managing a patient clinically or when performing high quality utilization review. Commenter compares the ODG neurological criteria with *Hoppenfied's Orthopedic Neurology* and Dermatome Maps to opine that the ODG criteria for lumbar discectomy is not generally accepted and could result in unnecessary surgery.

Agency Response: The Division disagrees that ODG is not designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care. ODG provides clear data on optimum frequency and duration of treatments. The ODG treatment guidelines explain that claims should ideally be managed based on the details of the case using the "Procedure Summary." The ODG Procedure Summary includes possible therapies, diagnostic methods, and provides a summary with a reference to the most recent medical evidence with an indication of whether the procedure is recommended, not recommended, or under study. *See*, ODG at 14. Within a Procedure Summary, ODG provides guidelines for instruction that include specific utilization review criteria often presented in an algorithmic format. *See*, ODG at 16. "For surgical procedures that may be supported by high quality medical studies, ODG provides a decision matrix entitled 'ODG Indications for Surgery'™ that itemizes the decision-making process and patient selection criteria for successful outcomes from the surgery." *Id.* In addition, §134.600(p) requires preauthorization for outpatient surgical or ambulatory surgical services, spinal surgery, and certain repeat diagnostic studies to consider individual case information. Quality and timely care in workers' compensation cases have become synonymous with overall cost containment. The level of cost containment is directly proportional to the degree of over-utilization of medical treatment currently experienced in the system.

§137.100: Commenter states there are many areas where even ODG does not address specific diagnoses and interventions, particularly in the area of mental health and behavioral health care. Commenter consequently recommends the addition of language from §413.011(18-a) with explicit language that there will be many situations where ODG does not adequately address the service requested and other evidence-based guidelines and empirically based literature will need to be consulted.

Agency Response: The Division declines to make the recommended change. Treatments, services and diagnoses not specifically addressed in the treatment guidelines are addressed through the preauthorization or treatment planning processes and as such no additional language is necessary.

§137.100: Commenter states opposition to the Texas Department of Insurance's relegation of ACOEM as the proposed treatment guidelines and provides examples of the failure of the guidelines to assist health care providers in communicating with insurance carriers the care necessary for injured employees.

Agency Response: The Division clarifies that the ACOEM practice guidelines are not adopted as treatment guidelines for use in the non-network worker's compensation system. However, the Division notes that certified workers' compensation health care networks have the flexibility to utilize these or other guidelines according to their individual business practices.

§137.100: Commenter recommends the rules adopted by the Commissioner should amend the definition of "evidence-based medicine" to replicate the definitions provided in a position statement and defined by the AAOS (evidence-based practice; best research evidence; clinical expertise; and patient values).

Agency Response: The Division declines to make the recommended change as Labor Code §401.011(18-a) defines evidence-based medicine.

§137.100: Commenter states no evidence exists indicating that ODG will compromise an injured employee's access to spinal surgery. Commenter also states that spinal surgeries will continue to go through the preauthorization process and can proceed to a review by an IRO if the insurance carrier denies preauthorization. Commenter states spinal surgery utilization is still a problem in Texas, as indicated by the Research and Oversight Council's January 2001 report "Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System," and will be addressed in an appropriate manner by adoption of the ODG treatment guidelines.

Agency Response: The Division agrees and clarifies that all spinal surgeries require preauthorization as established in §413.014 of the Labor Code. If a health care provider recommends spinal surgery, preauthorization is required in accordance with §134.600. The Division agrees that spinal injuries are a significant cost in the Texas workers' compensation system and that ODG is a useful tool in managing spinal injuries.

§137.100: Commenter states that the insurance industry is cognizant of the Texas Labor Code provision that prohibits the denial of health care based solely on the treatment guideline adopted by the Division or on the basis that health care being proposed or that has been rendered either exceeds the treatment guideline or is not included in the guideline.

Agency Response: The Division notes that adopted §137.100(g), proposed as subsection (h), requires that the insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

§137.100: Commenter urges the Division not to include a provision stating that health care treatment is automatically preauthorized if it falls within the treatment guideline.

Agency Response: The Division agrees. Adopted §137.100(e), proposed as subsection (f), states that an insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

§137.100: Commenter recommends changes to ODG's treatment guidelines that adds the terms "electrical" to all references pertaining to "bone growth stimulators, " and adds "therapy" to the title relating to "Cold/Heat Pack" to read "Cold Therapy/Heat Pack."

Agency Response: The Division declines to make the change. Commenter's specific recommendations for changes in language in ODG or other Division adopted guidelines is best addressed with the publisher of the guidelines.

§137.100: Commenters state that the ratings given to a number of the abstracts in the low back chapter and a reference in the pain chapter from Kumar with regard to the use of spinal cord stimulation for failed back surgery syndrome (FBSS) are incorrect. Commenter provides that in most of the examples provided, studies were classified as randomized controlled trials (Type 2) but were actually either cohort studies or case series, while other studies were classified as systematic reviews (Type 1) but were actually narrative reviews or other forms of evidence. Commenter provides that ODG classified in error a case series by Kumar as a randomized controlled trial leading to the conclusion that spinal cord stimulators (SCS) are "recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated for FBSS and complex regional pain syndrome (CRPS) Type 1. Commenter believes more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain and states that appropriately reclassifying the Kumar article would remove the evidence in favor of SCS for FBSS. Commenter concedes that it is unknown the degree to which the classification errors found in the low back chapter exists in the other chapters of ODG and recommends identifying similar errors prior to using the stated information. Commenter further recommends ascertaining the degree to which search criteria identified all relevant articles, the credentials of those rating the articles, and whether the ratings were based solely on reading the abstracts or the entire article.

Agency Response: The Division believes the commenter has highlighted a unique strength of ODG. Each treatment guideline summary and subsequent recommendation in ODG is hyper-linked into the studies on which it is based, in abstract form, which have been ranked, highlighted and indexed. (See "ODG Methodology Outline" at *www.odg-disability.com/methodology_outline.pdf.*) This accountability and transparency in ODG lets users evaluate the strength of medical evidence behind guideline recommendations on their own. Then, if they disagree with the ODG rating of a study, the ODG interpretation of a study, or if they think ODG has overlooked a specific study, they are encouraged to provide their feedback to the ODG authors, and these comments are then reviewed and reflected in the guidelines as appropriate. The editorial effort behind *ODG Treatment* is an open process, and its success is based on its reputation for being (1) unique in taking evidence-based guidelines to their logical end point, with the conclusions linked directly to the evidence in the studies and references; (2) continuously updated reflecting the findings of new studies as they are conducted and released so subscribers are always up to date; (3) comprehensive, covering all types of treatments and the relevant studies; and (4) independent and multidisciplinary in scope. (See "The Unique and Major Advantages ODG" at *www.odg-disability.com/Advantages of Official Disability Guidelines.pdf.*)

The Division disagrees that the rating studies on spinal cord stimulation are inaccurate. The only specific example produced by commenter says, "ODG classified in error a case series by Kumar as a randomized controlled trial." The link shown in the Pain Chapter under Spinal cord stimulators (SCS) listed as "(Kumar, 2006)" says, "Rating: 4a" (*www.odg-twc.com/odgtwc/pain.htm#Kumar4*). The rating level 4 is a Case Series and not a Controlled Trial (*www.odg-twc.com/odgtwc/ExplanationofMedicalLiteratureRatings.htm*). Commenter says that in "most" of the examples provided, studies were classified as Type 2, while other studies were classified Type 1. The Division does not agree with this assessment because there are a total of 41 studies cited under Spinal Cord Stimulation, and 6 received a Type 1 rating, while 8 received a Type 2 rating (less than 20% of the total, not qualifying as "most," see *www.odg-twc.com/odgtwc/pain.htm - SCS_References*). Commenter said that more trials are needed to confirm whether spinal cord stimulation is an effective treatment for failed back surgery syndrome. The commenter's opinion is not unreasonable, but ODG already limits the use of spinal cord stimulation to very unusual situations, since failed back surgery syndrome is the result of a failed spinal fusion, and ODG concludes, "Not recommended" for Fusion in the Low Back Chapter so ideally failed back surgery syndrome should almost never happen. Commenter recommends identifying "similar errors" prior to using ODG. The Division believes this is not an error and no "similar errors" have been identified. Commenter further recommends ascertaining the degree to which search criteria identified all relevant articles, the credentials of those rating the articles, and whether the ratings were based solely on reading the abstracts or the entire article. The evidence used for ODG is the complete article; however, ODG users have access to the abstract which serves as an article summary, and can help the user decide whether to review the complete article on their own. See "ODG Methodology Outline" at *www.odg-disability.com/methodology_outline.pdf* for a complete description of methodology.

§137.100: Commenter believes characterizing abstracts as evidence within the context of evidence-based medicine is inappropriate and potentially misleading. Abstracts are to be used as a guide to the evidence, but are not to be used in place of the evidence. Commenter states that the ODG chapter on pain and the use of spinal cord stimulators recommends trial stimulation supported by a link to the abstract. The user of ODG would assume from the statement and the link that the underlying medical study support trial stimulation. Commenter provides that the link on ODG is to an abstract for a protocol for a Cochrane Review and, according to Cochrane, "a protocol is the rationale for the review," not the systematic review itself. Commenter states ODG does not provide a link to the actual systematic public study concluding the opposite of the ODG procedure summary that found "no data regarding the benefits of having a trial stimulation period." Commenter further states separate studies are not reaching different conclusions, but misuse of the very same study.

Agency Response: The Division disagrees with commenter's interpretation of ODG. According to ODG methodology the complete article is reviewed. ODG users have access to the abstract which serves as an article summary, and can help them decide whether to review the complete article on their own. See "ODG Methodology Outline" at *www.odg-disability.com/methodology_outline.pdf* for a complete description of methodology. The link at (Mailis-Gagnon-Cochrane, 2004) goes to a Cochrane systematic review (*www.odg-twc.com/odgtwc/pain.htm - MailisGagnon*) which says, "Mailis-Gagnon A, Furlan A, Sandoval J, Taylor R, Spinal cord stimulation for chronic pain, Cochrane Database Syst Rev. 2004;3:CD003783" and, "CONCLUSIONS: Although there is limited evidence in favour of SCS for Failed Back Surgery Syndrome and Complex Regional Pain Syndrome Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain."

§137.100: Commenter states the representation that ODG covers conditions that represent over 99% of workers' compensation costs is a gross overstatement. For comparison, a 2004 study by the California Workers Compensation Institute showed that for California data, 30% of claims had diagnoses that were too non-specific to apply guidelines, and 20% were trauma, primarily lacerations and fractures. *Evidence-Based Medicine & The California Workers' Compensation: A Report to the Industry,* California Workers' Compensation Institute, Harris, Swedlow, February 2004.

Agency Response: The Division acknowledges differences among treatment guidelines. Jeffrey S. Harris, MD, MPH, MBA, Alex Swedlow, MHSA, California Workers Compensation Institute, *Evidence-Based Medicine & The California Workers' Compensation System: A Report to the Industry*, 14-17 (2004) states that trauma and non-specific claims involve 51.7% of all California workers' compensation claims and 42.3% of total benefit costs, which the adopted state guidelines did not cover at the time of the report. Additionally, the 2004 report notes that guidelines for trauma injuries that include fractures, burns, and lacerations were not expressly developed for the adopted California state guidelines due to well-defined treatment pathways and anecdotal studies of less treatment variability. Based on the January 2004 report, a few of the primary diagnosis codes for non-specific claims that did not fit within the adopted California state guideline diagnostic criteria included 784.0-headache; 854.00-brain injury; 719.46-joint pain, lower leg, and 729.5-pain in limb. However, there are notable differences between California's adopted guidelines at the time of the reported study and the current ODG. For instance, specific treatment guidelines are provided in ODG for injuries involving burns, the head, the leg, and pain. Given the differences between the guidelines, the fact that a similar study specific to ODG and workers' compensation injuries in the state of Texas has not been conducted, it is probable that the results would yield different comparative percentages. Although a specific study has not been conducted to validate WLDI's representations, the Division notes that ODG does cover all the major body parts likely to be involved in a workers' compensation injury. This comprehensiveness supports the conclusions that ODG addresses the overwhelming majority of workers' compensation medical costs.

§137.100: A commenter provides documentation which indicates that Lippincott Williams & Wilkins, the publisher of the Journal of Occupational and Environment Medicine (JOEM), has asked the Work Loss Data Institute to cease and desist from the use of JOEM abstracts and other JOEM publications because use of JOEM proprietary materials is unauthorized and must cease immediately, and because the Work Loss Data Institute is mischaracterizing the abstracts as evidence which is not the intended purpose of the JOEM abstracts.

Agency Response: It is the understanding of the Division that the abstracts are provided as a summary to assist the user in knowing which studies may be appropriate for review in order to evaluate the strength of the medical evidence behind the guidelines. The reported controversy between Lippincott Williams &

Wilkins, and the Work Loss Data Institute, referred to by the commenter, is a topic outside the scope of this rule making activity and does not affect the Division's choice of the ODG treatment guidelines.

§137.100: Commenter states that ODG listed treatment guidelines written by health care entities such as Blue Cross and Aetna as a high quality reference when such guidelines have never been considered evidence in any other treatment guideline. A high level systematic review only gives an article high quality weight when performed as a high quality randomized controlled trial.

Agency Response: According to the *WLDI Methodology Outline*, ODG prefers an article written in the English language that satisfies a certain criterion. WLDI ODG gives preference to evidence that is a systematic review of the relevant medical literature. WLDI considers an article that reports a randomized controlled trial or a controlled trial. WLDI also considers an article that reports a prospective cohort study or a retrospective study. WLDI further considers an article that reports a case control series involving at least 25 subjects in which the assessment of the outcome was determined by the person or entity independent from the persons or institution that performed the intervention, the outcome of which is being assessed. When there are limited studies available with the preferred criteria, it becomes necessary to review other studies, and rank the evidence alphanumerically from 1a to 10c based on the type of evidence (1-Systematic Review/Meta-Analysis, 2-Controlled Trial -Randomized (RCT) or Controlled, 3-Cohort Study-Prospective or Retrospective, 4-Case Control Series, 5-Unstructured Review, 6-Nationally Recognized Treatment Guideline from guidelines.gov, 7-State/Other Treatment Guideline, 8-Foreign Treatment Guideline, 9-Textbook, 10-Conference Proceedings/Presentation Slides). The evidence is further ranked by the quality within the type of evidence (a-High Quality, b-medium quality, and c-low quality) using the methodology in the second chapter of ODG. Generally, using the ODG alphanumeric methodology, treatment guidelines from health care entities such as Blue Cross and Aetna would receive a rating of 7 - State/Other Treatment Guideline which is lower than a rating of 1 - Systematic Review/Meta-Analysis or 2 - Controlled Trial-Randomized (RCT) or Controlled unless studies from a health insurance company were published in the peer-reviewed literature, in which instance such studies could receive a higher ranking. Further, whether a particular treatment is covered or not covered by health care insurance should be relevant to coverage decisions in workers' compensation.

§137.100: Commenter opines that ODG is overly comprehensive, including numerous low level studies.

Agency Response: The Division disagrees. WLDI gives prefers an article written in the English language that satisfies a certain criterion. WLDI gives preference to evidence that is a systematic review of the relevant medical literature. WLDI considers an article that reports a controlled trial-randomized or controlled. WLDI considers an article that reports a cohort study, whether prospective or retrospective. WLDI considers an article that reports a case control series involving at least 25 subjects in which the assessment of the outcome was determined by the person or entity independent from the persons or institution that performed the intervention the outcome of which is being assessed. When there are limited studies available with the preferred criteria, it becomes necessary to review other studies, and rank the evidence alphanumerically from 1a to 10c based on the type of evidence (1-Systematic Review/Meta-Analysis, 2-Controlled Trial -Randomized (RCT) or Controlled, 3-Cohort Study-Prospective or Retrospective, 4-Case Control Series, 5-Unstructured Review, 6-Nationally Recognized Treatment Guideline from guidelines.gov, 7-State/Other Treatment Guideline, 8-Foreign Treatment Guideline, 9-Textbook, 10-Conference Proceedings/Presentation Slides). The evidence is further rated by the quality within the type of evidence (a-High Quality, b-medium quality, and c-low quality) using the methodology in the second chapter of ODG. According to David L. Sackett, William M.C. Rosenberg, J.A. Muir Gray, R. Brian Haynes, and W. Scott Richardson, *Evidence Based Medicine: What It Is and What It Isn't,* BMJ 312 (7023), 13 January, 71-72, "if no randomized trial has been carried out for [the] patient's predicament, we must follow the trail to the next best external evidence and work from there." Further, Lisa A. Bero, Ph.D, *Evaluating Systematic Reviews and Meta-Analyses*, Journal of Law and Policy 580 (2006), citing, Debra J. Cook et. al., *Should Unpublished Data Be Included in Meta-analyses? Current Convictions and Controversies,* 269 JAMA 2749, 2749-53 (1993) reports that the "majority of methodologists and journal editors now believe that unpublished data should be included in systematic reviews, suggesting widespread belief that important data remain unpublished."

§137.100: Commenter recommends an independent, in-depth assessment of proposed guidelines by qualified medical and epidemiologic professionals prior to adoption. Commenter further states that sales or vendor presentations in support of particular proposed guidelines do not generally provide the specificity, depth, and breadth of analysis necessary to assure maximum benefit for injured employees.

Agency Response: The Division disagrees that it has not thoroughly reviewed the adopted guidelines. Prior to proposal, the Division considered the merits of various published return to work guidelines and treatment guidelines. Several stakeholder and work group meetings were held to discuss the disability management concept and rules related to guidelines. In addition, meetings were held with guideline publishers. Representatives of various guidelines made presentations to Division staff and workers' compensation system stakeholders regarding the development and use of their individual guidelines. After reviewing and evaluating these guidelines and stakeholder input, as well as considering the recommendations of the Division's Medical Advisor and the former Texas Workers' Compensation Commission Medical Advisory Committee's Return to Work workgroup, the Division selected the guidelines.

§137.100: Commenter recommends that clarification be made as to potential physician licensing and malpractice allegations if the doctor performs a procedure or treatment within the adopted treatment guidelines, specifically surgical discectomy. Commenter questioned whether doctors violate the standard of care in Texas if they follow the Division treatment guidelines.

Agency Response: The Division acknowledges the concern regarding a physician's compliance with a duty to follow the standard of care in the medical profession when treating an injured employee. The Division clarifies that all spinal surgeries require preauthorization in accordance with Labor Code §413.014 and preauthorization requests are evaluated for medical necessity on a case-by-case basis. The Division disagrees that treatment guidelines establish the standard of care for a physician in Texas. The WLDI discloses in its ODG treatment guidelines that it is "not engaged in rendering medical advice, legal, or professional ad-

vice. The final opinion regarding any medical condition and the ability of a patient to return to work should rest with the physician." According to medical literature, treatment guidelines do not establish legal standards for clinical care but may provide the courts with a benchmark by which to determine clinical conduct in the workers' compensation system. Brian Hurwitz, *How Does Evidence Based Guidance Influence Determinations of Medical Negligence?*, 329 BMJ 1028 (2004); Ash Samanta, M.D., L.L.B., Jo Samanta, B.A., Michael Gunn, L.L.B., *Legal Considerations of Clinical Guidelines: Will NICE Make A Difference?*, 96 Journal of the Royal Society of Medicine, 134 (2003). This perspective from the medical literature appears consistent with the legal precedence in Texas. In *Denton Regional Med. Ctr. v. Lacroix*, 947 S.W. 2d 941, 951 (Tex. App. Fort Worth 1997), the court held that although it may consider the hospital's internal policies and bylaws, as well as the Joint Commission on Accreditation of Health Care Organizations standards in determining the standard of care, those factors alone do not determine the standard of care. Therefore, it is the Division's opinion, that in using the treatment guidelines as only a benchmark for determining appropriate care, the physician must ultimately consider the individual circumstances and needs of the injured employee and act according to the applicable standards of care for his particular medical profession. The Division acknowledges that injured employees may require more or less treatment than provided in the treatment guidelines based on the specifics of the injury. The disability management rules recognize this and a variance from the guidelines should be supported by documentation.

§137.100: Commenter states it is incorrect that ODG is not evidence-based and that the methodology is flawed. Commenter includes an outline of ODG's methodology, which provides detail as to how ODG is created and remains evidence-based. Commenter additionally states that reviewers use actual studies, not abstracts, to formulate the conclusions for the guidelines and abstracts are provided as an accommodation to the subscribers. Commenter states an observation has been made that the guidelines lack evidencebased medicine. Commenter notes that the summarizations in ODG can only be as good as the studies that have been conducted and are available. Consequently, ODG can only rely on what's being studied and what is being released in terms of results and outcomes based on evidencebased science. ODG reads the studies themselves; however, only the abstracts are provided because it would be impossible to include the entire studies in a book or a database. In addition, studies are sometimes not available for publication. Commenter states that ODG provides on its website a dynamic database that provides the most current updates of studies or clinical trials. Commenter further states system participants are encouraged to utilize ODG's web-based version because the print version does not include studies completed and released after the annual publication of the hard-copy ODG. In addition, ODG offers discounts for system participants who choose to subscribe to the ODG web version rather than the book version.

Agency Response: The Division acknowledges the comments regarding ODG.

§137.100: Commenters state that ACOEM guidelines are the only treatment guidelines under consideration that meet the statutory standard outlined in Labor Code §413.011(e), and recommends its sole adoption in the State of Texas. Commenters state that ACOEM practice guidelines are the highest quality and most scientifically based and empirically validated guidelines currently available. Commenters further state that the ODG treatment guidelines do not meet the scientific principles for evidence-based medicine, therefore, not meeting the statutory tests of §413.011(e). A treatment guideline that references links to abstracts may appear to be evidence-based, but does not meet the Labor Code standard of being "scientifically valid." Commenter provides that ODG does not follow most of the steps integral to the widely accepted evidence-based medicine process described in the referenced publications. Commenter further provides that ODG does not describe the expert review and consensus process used to make testing and treatment recommendations or a scheme for rating individual systematic reviews or the body of high quality evidence to support each recommendation. Commenter comments that ODG does not describe its process for a multidisciplinary review or for external review other than a reference to an Editorial Advisory Board. Commenter provides examples and documentation to support this position.

Agency Response: The Division disagrees that ACOEM guidelines are the only guidelines that meet the statutory standards. The ODG treatment guidelines meet the statutory requirement for adoption in the State of Texas. Labor Code §413.011(e) requires the Commissioner to adopt treatment guidelines that are evidence-based, scientifically valid, and outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care.

The ODG guidelines are evidence-based. Labor Code §401.011 (18-a) defines "evidence-based medicine" to mean "the use of the current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients." The RAND Institute defined *evidence-based* and *peer-reviewed* to mean, at a minimum, a systematic review of literature published in medical journals included in the National Library of Medicine's MEDLINE, (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*). Finding that systematic reviews of the literature are standard and essential features of an evidence-based guideline development process, RAND determined that ODG was evidence-based and peer-reviewed, a criteria for inclusion in the RAND study of treatment guidelines. The ODG guidelines are scientifically valid. ODG follows the steps integral to the process of creating evidence-based treatment guidelines. WLDI describes its methodology for formulating the ODG treatment guidelines in the *ODG Methodology Outline* at *www.odg-disability.com/methodology_outline.pdf. ODG Treatment* also includes a detailed document entitled *Appendix A, Methodology Description Using the AGREE Instrument*. This Appendix provides an extensive explanation of how *ODG Treatment* meets each of the 23 criteria established by the *AGREE Instrument*, including the rigorous means of developing the guidelines as described by the criteria for selecting the evidence and the methods used for formulating the recommendations. The RAND Institute determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California*, p. 32).

The ODG guidelines are outcome-focused. The information in ODG is a compilation of the current medical evidence that reflects the outcomes of new studies and clinical trials. This data is integrated into the guidelines to reflect advances in medical technology, drug therapies, or alternative medicine techniques. Application of this information in a clinical setting has a positive

impact in shaping injured employee return to work outcomes. The *ODG Foreword* notes that studies included in the ODG are focused on one outcome: doing what is best for the injured employee. Additionally, the *ODG Foreword* reports the results of a study conducted in Ohio by CompManagement, Inc. The pilot study found that "following adoption of ODG statewide, results at CompManagement demonstrate savings in medical costs of 64 percent, in lost days of 69 percent, and minimized treatment delays."

Further, the ODG guidelines are designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care by providing clear data on optimum frequency and duration of treatments. The ODG treatment guidelines explain that claims should ideally be managed based on the details of the case using the "Procedure Summary." The ODG Procedure Summary includes possible therapies and diagnostic methods, and provides a summary and reference to the most recent medical evidence with an indication of whether the procedure is recommended, not recommended, or under study. Within a Procedure Summary, ODG provides guidelines for instruction that include specific utilization review criteria often presented in an algorithmic format. Quality and timely care in workers' compensation cases have become synonymous with overall cost containment. The level of cost containment is directly proportional to the degree of over-utilization of medical treatment currently experienced within the system. Therefore, ODG satisfies the statutory requirement for adoption of treatment guidelines in the State of Texas.

The Division disagrees that ODG does not describe its process for rating the evidence for the treatment recommendation. The process used to rate the evidence for the ODG treatment guidelines is provided in the *ODG Explanation of Medical Literature Ratings,* the *Methodology Outline*, and *Appendix A, Methodology Description using the AGREE Instrument.* The Division disagrees that ODG does not describe its expert review process. *ODG Treatment* includes a detailed document entitled *Appendix A, Methodology Description using the AGREE Instrument.* This Appendix includes information about the involvement of stakeholders and further describes the review process by the ODG Editorial Advisory Board in the rigor development portion.

§137.100: Commenter states that the abstracts of studies are mostly the work of others and few are original to ODG. Depending on journal policy, abstracts may be created for a variety of purposes, and cannot be presumed to represent "evidence" of a degree suitable for guideline development. Abstracts cannot be presumed to represent evidence of a degree suitable for guideline development.

Agency Response: The Division clarifies that actual studies, not abstracts, are used to formulate the conclusions for the guidelines and abstracts are provided as an accommodation to the subscribers. The RAND Institute determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* p. 32).

§137.100: Commenters state that although ODG cites numerous abstracts and guidelines to support its conclusions, misclassification of the evidence, the use of a simplistic method to assess study quality, failure to identify the means through which low quality evidence was used for recommendations, and not providing a description of how the advisory panel functions do not meet the criteria for evidence-based guidelines as set forth in the Agree Criteria and similar documents in the peer-reviewed literature.

Agency Response: The Division disagrees that ODG does not follow all of the steps integral to the process of creating evidence-based medical treatment guidelines. *ODG Treatment* includes a detailed document entitled *Appendix A, Methodology Description using the AGREE Instrument.* This Appendix provides an extensive explanation of how ODG Treatment meets each of the 23 criteria established by *AGREE*, including the rigorous means of developing the guidelines as described by the criteria for selecting the evidence and the methods used for formulating the recommendations. The Appendix describes stakeholder involvement with a reference to the *ODG Treatment in Workers' Comp. Editorial Advisory Board.* The *ODG Treatment Methodology Outline* describes the review by the ODG Editorial Advisory Board. The outline provides that "prior to publication, members of the ODG Editorial Advisory Board, as well as select organizations and individuals making up a cross-section of medical specialties and typical end-users externally review *ODG Treatment in Workers' Comp.* This same review process is continued on an annual basis." According to the *AGREE Instrument Training Manual 12* (2003), there is no standard by which the guideline advisory group should function, other than meeting the *AGREE Instrument* recommendation to have a representation of all the professional groups that are likely to use the guidelines, information about the composition of the guideline development group, which should include the affiliation and discipline of the group members. The RAND Institute determined that ODG, and the other four guidelines studied, scored high in the rigor of development domain by clearly describing the methods used to search for evidence and formulate recommendations. Further, the RAND study found that ODG, and the other guidelines studied, included most of the relevant groups in the guideline development process. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* p.32).

§137.100: Commenter questions whether the guidelines are editorially independent from the funding body since the ODG methodology outline acknowledges that contributors may be compensated. Commenter states that litigation is pending against the WLDI in federal court in the case of *Ranavaya v. WLDI*, U.S. District Court for the S.D. of West Virginia, Case No. 2:05-CV-109. Commenter provides documentation of the complaint and states that the plaintiff alleges breach of contract in connection with a royalty agreement, breach of a confidentiality agreement, and conversion of confidential business information. Commenter notes the pending litigation reveals that compensation to editors and contributors can include commissions on sales of products. Commenter takes no position on the merits of the case. Commenter further states that item 22 of the *"Methodology Description Using the AGREE Instrument"* provides that "The guideline is editorially independent from the funding body." Commenter provides that ODG revised item 22 of the *AGREE Instrument* to state "The guideline is editorially independent from the functioning body."

Agency Response: The Division disagrees that ODG is not editorially independent from the funding body. WLDI discloses in ODG that "the funding body is WLDI, an independent database development company focused on workplace health and productivity, founded in 1995, to create, maintain and market information databases to implement standards for managing workforce productivity based on strict principals of evidence-based methodology, with ongoing focus on health care cost contain-

ment. There are no conflicts of interest among the guideline development members." The RAND Institute used the *AGREE Instrument* to evaluate the editorial independence of ODG. (RAND, *Evaluating Medical Treatment Guideline Sets for Injured Workers in California* p. xx and 33). To demonstrate editorial independence, it is necessary to demonstrate that a guideline is editorially independent from the funding body, and that conflicts of interest of guideline development members are recorded. *Id.* at 30. Applying the *AGREE Instrument*, the RAND Institute, determined that ODG demonstrated the editorial independence of its development group. *Id.* at p. xx and 33.

§137.100: Commenter provides that procedural summaries should indicate whether linked articles are rated as high quality evidence or low quality evidence. Commenter believes that listing low quality articles in the high quality article section mischaracterizes and bolsters the low quality article. Commenter states there is no indication that the links meet the statutory requirements of being evidence based and scientifically valid. Commenters provide examples to support this position.

Agency Response: The Division disagrees. Each article cited in ODG receives a rating, indicating the level of quality. These quality ratings are contained with the article summary, and they are available to users when they click on the links to each article. See, *ODG Explanation of Medical Literature Ratings.* Within the Procedure Summaries, there are no high quality article sections or low quality article sections. Each treatment guideline summary and subsequent recommendation in ODG is hyper-linked into the studies on which it is based, in abstract form, which have been ranked, highlighted and indexed. See ODG Methodology Outline at *www.odg-disability.com/methodology_outline.pdf.* These references allow users to evaluate the strength of medical evidence behind guideline recommendations. If they disagree with the ODG rating of a study, the ODG interpretation of a study, or if they think ODG has overlooked a specific study, they are encouraged to provide their feedback to the ODG authors. The classification of the article as a high priority reference or a low priority reference appears after the procedure summary and in the summaries of the medical studies. The summaries of the medical studies include a rating to evaluate the quality of the study.

§137.100(a): Commenter recommends return to work and treatment guidelines be the same for both in network and non-network claims as it would be less confusing.

Agency Response: The Division is unable to make this change because workers' compensation networks are governed by the Insurance Code. Workers' compensation health care networks certified in accordance with Insurance Code §1305 may choose a treatment guideline or guidelines to suit their individual business requirements and health care models. It is not feasible for the Division to adopt multiple guidelines and maintain a consistency with all certified networks. The position of the Division is that this would create greater confusion and would not lead to any kind of consistency.

§137.100(a): Commenter states ODG guidelines were formulated by occupational medicine doctors, and not orthopedic surgeons or neurosurgeons, even though orthopedic surgeons or neurosurgeons will manage 80-85% of the serious workers' compensation injuries.

Agency Response: The Division disagrees. According to the *ODG Treatment in Workers' Comp*, 26 (2006); *ODG Treatment in Workers' Comp, Editorial Advisory Board*, 5-8 (2006); and *ODG Treatment in Worker's Comp, Methodology Description Using the AGREE Instrument*, 1573-1574 (2006), ODG is independent of any medical specialty group and multidisciplinary in scope. These references further support that ODG represents various medical specialties, including occupational medicine doctors, orthopedic surgeons, chiropractors, and physical therapists.

§137.100(a): Commenter recommends the ODG treatment materials should efface any return to work content. Commenter supports this recommendation with a statement that the effectiveness of MDA return to work guidelines may be jeopardized by the format and structure of the ODG's intermingling of return to work guidelines throughout their treatment recommendations. This intermingling will expose non-network claims users to the risk of applying the incorrect ODG return to work information on Texas employees.

Agency Response: The Division agrees and §137.100 is revised to indicate that the adoption of ODG Treatment in Workers Comp does not include the ODG return to work pathways.

§137.100(a): Commenters support ODG. A commenter states the ODG offers strong evidence-based support for the use of behavioral interventions among injured employees and for those with chronic conditions. Another commenter states the adoption of ODG will best serve the purpose intended by the Texas Legislature to serve as a treatment guideline required for use in non-network claims. Commenters state ODG incorporates an integrated approach, which includes a section promoting patient education and involvement in their own care. Commenter also states ODG is used successfully in 13 other states and provinces, decreases costs, and is totally independent, not related to any medical organization. Commenter states they have adopted and utilize ODG treatment guidelines as an educational tool for member physicians, especially for non-occupational medicine doctors. Commenter also states that for physicians who have purchased ODG the cost has not been an issue.

Agency Response: The Division appreciates the supportive comments regarding the use of ODG.

§137.100(a): Commenter opines that sections of the ODG do not have a specific evidentiary basis, and provides the example of intervals between medical visits and number of physical therapy visits outlined. Commenter states there may be incongruence between the health care provider's treatment plan and what is in the guidelines.

Agency Response: The Division agrees that although in certain circumstances incongruence between the guidelines and the health care provider's treatment plan may occur, both health care providers and insurance carriers must apply the disability management concepts in a manner that supports the goal of improved return to work outcomes.

§137.100(a): Commenter recommends deletion of a bifurcated system approach (e.g., network vs. non-network) with the following language substitution: "Health care providers shall provide treatment in accordance with treatment guidelines that are being used by workers' compensation health care networks."

Agency Response: The Division disagrees. Such an approach leads to uncertainty as to which guideline is being used. Network choices are based on individual business practices and health care models adopted by the network and are not necessarily consistent between networks. Consequently, it is not feasible for the Division to adopt the same guidelines as certified health care networks and maintain a consistency with all certified networks.

137.100(a): Commenter recommends the use of ACOEM as a treatment guideline. Commenters, in the alternative, suggest use of two guidelines when the primary guideline does not address the condition or procedure. Commenter recommends the use of ACOEM and ODG while the Division reevaluates both in more depth. Commenter suggests using ACOEM as the primary guideline and ODG as the secondary guideline for treatment not covered by ACOEM. Commenter further recommends the use of other guidelines or evidence when a condition or procedure is not sufficiently addressed by ODG or ACOEM. Another commenter states the proposed rule will create significant confusion among Texas employees, network health care providers and third parties because the Division has selected a single treatment guideline that would apply only in non-network care. Commenter asserts that the validity of ODG evidence-based guidelines being linked to the evidence in the studies and references relevant to specific treatment is questionable. ODG guidelines are based on selected studies, many of which do not meet reasonable, scientific criteria. Commenter believes ODG does not include a comprehensive and critical review of relevant literature in support of many of the guidelines, especially those related to the management of pain. Commenter additionally disagrees that ODG meets the criteria for recognition by AHRQ, as official acknowledgment of privately sponsored guidelines does not exist.

Agency Response: The Division declines to adopt ACOEM instead of ODG, or to adopt ACOEM in addition to ODG, at this time. The adopted ODG meets the requirement of the Labor Code, is consistent with the goals of the Division and at this time best meets the objectives of HB 7. However, the Division agrees that documentation may be submitted to support a diagnosis or treatment not addressed by ODG. Such documentation could include other guidelines, such as ACOEM, when certain treatments or services are not included or addressed by ODG. The Division disagrees that confusion will occur among Texas employees, network health care providers and third parties because the Division has selected a single treatment guideline that would apply only in non-network care. The Division disagrees that ODG does not include a comprehensive review of the literature in support of the treatment guideline. Actual studies, not abstracts, are reviewed to formulate the guideline recommendations. *The ODG Methodology Outline* provides sufficient detail about the development of ODG. The recommendations are based on the available studies that have been conducted and released, noting that studies are sometimes not available for publication. With regard to the management of pain, *ODG* includes a treatment guideline devoted specifically to pain. *ODG* indicates that its higher priority references for the management of pain address behavioral interventions, complementary alternative medicine, injections, low back pain, medical treatment guidelines, medications, assessment and management, chronic pain, miscellaneous, psychological evaluation and treatment, reflex sympathetic complex regional pain syndrome, therapeutic intervention, and spinal cord stimulation. *ODG* at 1258-1272. *ODG* indicates that its low priority references for the management of pain address complimentary alternative medicine, injections, low back pain, medical treatment guidelines, medications, assessment and management, chronic pain, miscellaneous, psychological evaluation and treatment, and therapeutic intervention. *ODG* 1273-1276. The Division acknowledges that inclusion of a guideline in the National Guideline Clearinghouse does not constitute an endorsement or recognition by AHRQ or any of its contractors of the guideline.

§137.100(a): Commenter recommends adoption of at least one set of treatment guidelines that have been developed by the medical profession, such as ACOEM. Commenter states this would ensure that practicing orthopedists have the flexibility to treat injured employees in the most clinically appropriate way and to ensure consistency with care that may be provided in network settings.

Agency Response: The Division declines to make the recommended change. The adopted ODG meets the requirement of the Labor Code, is consistent with the goals of the Division, and best meets the objectives of HB 7. The Division anticipates health care providers' ability to use these tools, and the treatment guidelines as a framework to develop treatment for injured employees. The health care provider must consider care above or below the guidelines consistent with the unique factors associated with an injury. The rules anticipate certain care outside or inconsistent with the treatment guidelines be managed through treatment planning and coordinated with the preauthorization process. Injured employees continue to be entitled to necessary medical care in accordance with Labor Code §408.021. The Division will monitor the use of the disability management tools by all system participants to assure compliance with the intent of HB 7.

§137.100(a): Commenter is encouraged that the chosen guidelines meet the National Guidelines Clearinghouse's inclusion criteria. Commenter recommends that the Division consider development of a continuous monitoring of treatment guidelines implementation with practicing physician input. Commenter states the Division should understand that no single set of guidelines will address all medical situations and that adopted guidelines will be imperfect and need constant review and editing.

Agency Response: The Division position is that meeting the criteria for inclusion in the National Guidelines Clearinghouse registry supports the selection of ODG as Division treatment guidelines. The Division also agrees that the studies and research supporting evidence-based medicine are dynamic. ODG's web version includes ongoing review and updates as new research and studies become available.

§137.100(a): Commenter recommends clarification to state that treatment in conformance with the adopted guidelines are binding unless a particular patient has a diagnosis or needs a therapy regimen, surgery or treatment not covered by the ODG treatment guidelines. Commenter states that ODG is not a default treatment guideline to a preferred one selected by the insurance carrier.

Agency Response: The Division disagrees that additional clarification is necessary. Care within the guidelines is presumed reasonable and reasonably required as stated in §137.100(c). Such care may be retrospectively reviewed by the insurance carrier to confirm medical necessity. Care not addressed by the guidelines or that exceeds the guidelines requires preauthorization, in some cases the preauthorization request may be through a treatment plan. The Division agrees that ODG is the adopted Division treatment guidelines.

§137.100(a): Commenter recommends the adoption of one treatment guideline for the workers' compensation system, as this would facilitate recruitment of physicians.

Agency Response: The Division agrees that treatment and return to work guidelines help establish benchmarks for treatment and return to work for the workers' compensation system. Standards tend to clarify the expectations of system participants and

should, when fully integrated into the system, decrease administrative hassles. In the long term this approach should improve injured employees' access to care.

§137.100(c): Commenters have concerns with provisions in the rule proposals that would allow health care providers to submit treatment plan for services that are provided in accordance with the Division treatment guidelines. Submission of a treatment plan to an insurance carrier for preauthorization for services that are presumed to be "reasonable" and "reasonably required" to the insurance carrier would unnecessarily add requirements and costs to stakeholders.

Agency Response: The Division agrees that this provision when applied with proposed §137.100(d) could be burdensome to insurance carriers. Subsection (d), as proposed, is deleted and clarifying language regarding care within the guidelines and treatment plans has been added to §137.300.

§137.100(c): Commenter recommends the rule require IROs to consider the treatment guidelines adopted and explain any deviation.

Agency Response: The Division disagrees that additional language regarding IROs is necessary or appropriate within this section. The position of the Division is that IRO decisions should be fully explained and documented in accordance with applicable IRO rules.

§137.100(c): Commenter recommends deleting the §401.011(22-a) Labor Code reference from the rule, so that the subsection would read, "Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017."

Agency Response: The Division disagrees with commenter's recommendation because inclusion of both statutory definitions is necessary to properly convey the Division's policy which includes both reasonable and reasonably required health care.

§137.100(c): Commenter recommends clarification that presumption of reasonableness of care will only be applied when the underlying diagnosis of the care is undisputed, or upon final resolution of the diagnosis in dispute.

Agency Response: The Division disagrees with commenter's recommendation because issues of compensability, extent of injury and liability and how those issues are resolved are outside the scope of this rule. These new sections relate to disability management and any issues of compensability, extent of injury and liability will still need to be addressed by the appropriate statutes and rules.

§137.100(c): Commenters recommend adding the following language to subsection (c): "Health care services should not be denied or approved simply because they are included or excluded from the Division treatment guidelines." Not all services listed in the guidelines will be medically necessary for every patient, just as some patients may need services in excess of those listed in accordance with the treatment guidelines. The basis of evidence-based guidelines is that the clinical presentation of the patient allows the physician to prescribe the most appropriate and effective treatment.

Agency Response: The Division declines to make the recommended changes. Adopted subsection (e) allows insurance carriers to retrospectively review treatment within the guidelines for medical necessity. This is consistent with the concept that not all care is necessary in every instance.

§137.100(c): Commenter believes the intent of HB 7 and these rules is that treatments contemplated in the guidelines are presumed appropriate and necessary only where the health care provider's diagnosis is based on objective, documented, evidence-based medical findings (e.g., not subjective complaints alone) be clearly stated in the rule. Commenter states this concept helps to clarify what health care providers must do before enjoying the presumption of medical necessity.

Agency Response: The disability management concept and corresponding guidelines are intended as a tool to assist system participants not to limit necessary health care services. If an insurance carrier disputes a diagnosis they may seek a treating doctor examination to define the compensable injury or a designated doctor examination. The Division clarifies that issues related to compensability, extent of injury and liability are outside the scope of this rule.

§137.100(c): Commenter is concerned that this subsection is too rigid and does not take into account claims in which the treatment required to "cure or relieve" the compensable injury will exceed the adopted treatment guidelines.

Agency Response: The Division acknowledges the commenter's concerns and notes that the adoption of treatment guidelines does not diminish the provisions of §408.021 of the Labor Code. The adopted disability management rules are intended to facilitate the efficient delivery of health care and promote early and appropriate return to work.

§137.100(d) and §137.300(b): Commenter recommends reduction of the "hassle factor" in order to get more medical providers back into the workers' compensation system. Commenter recommends that if treatment guidelines are adopted, then a doctor treating within the guidelines should be automatically preauthorized and automatic preauthorization means that they will be paid unless it is found non-compensable.

Agency Response: The Division agrees that reducing hassle factors in the workers' compensation system is an important concept in developing a health care provider-friendly environment and intends for the treatment guidelines to provide a framework of benchmarks for system participants. These benchmarks help define expectations and health care providers benefit from clear expectations. The Division disagrees that care within the guidelines be deemed preauthorized. Although care within the guidelines is presumed reasonable and reasonably required, it is unlikely that all care within the guidelines will be medically necessary or required in each specific case. The treatment guideline rule allows the insurance carrier, when appropriate, to deny payment for care that is not medically necessary even though the care was included in the guideline. That denial of payment must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

§137.100(d): Commenter supports the inclusion of the term "health care provider" as opposed to doctor throughout the rule as it keeps the proposed rule consistent with the Division preauthorization rule.

Agency Response: The Division agrees that the reference was not clear and subsection (d) is deleted. Reference to this process is more appropriately addressed in the §137.300 and is clarified in that section.

§137.100(d): Commenter states that to require preauthorization of a treatment plan negates voluntary certification as allowed

by §413.013(f). Another commenter also suggests that education efforts are needed to promote the more appropriate use of voluntary certification for participants, as commenter advocates for the deletion of the proposed preauthorization of care for treatments and services within the adopted guideline. Commenters also state that this provision is in conflict with Labor Code §413.014(f), which provides that an insurance carrier and health care provider may voluntarily discuss health care treatment and treatment plans, and, the insurance carrier may certify or agree to pay for health care consistent with these agreements.

Agency Response: The Division disagrees the treatment guidelines conflict with the Labor Code. Insurance carriers and health care providers may continue to discuss and voluntarily certify care not subject to the preauthorization and concurrent review requirements of Division §134.600. The Division disagrees that additional education efforts are necessary to facilitate voluntary certification. After four years of Division data collection efforts regarding preauthorization and voluntary certification, it is noted that voluntary certification is used infrequently. Anecdotally, health care providers have reported to the Division the unwillingness of insurance carriers to significantly participate in the voluntary certification process.

§137.100(d): Commenter states that the insurance carrier is allowed to deny any recommendation beyond the guidelines as being unreasonable or not medically necessary, while the rule as a whole seems to state all medical treatment is limited to that provided in the guidelines, or subject to a preauthorized treatment plan when the proposed treatment exceeds the guidelines.

Agency Response: The Division clarifies that injured employees are entitled to medical services as specified in the Labor Code. Adoption of treatment guidelines and treatment planning provide benchmarks for system participants to develop treatment for injured employees. The Division anticipates certain care may be outside or inconsistent with the treatment guidelines and in order to efficiently manage those situations the rules implement treatment plans so that injured employees may continue to receive necessary medical care in accordance with the Labor Code.

§137.100(d): Commenter recommends if the proposed requirements for treatment plans are adopted, then commenter recommends deletion of subsection (d). Commenter states the rules as proposed could be an unnecessary administrative burden on system participants.

Agency Response: The Division clarifies that subsection (d) as proposed is deleted. Requirements related to treatment planning are included in §137.300.

§137.100(d) and (f): Commenter states that the implementation of these rules will be a learning curve and behavior change for all system participants, and further states no one should believe that medical necessity denials for inappropriate care will cease with adopted treatment guidelines.

Agency Response: The Division believes that the framework of treatment guidelines and treatment planning should lead to a better understanding of overall system benchmarks. Appropriate consistent use and application of these tools should decrease inappropriate treatments and inappropriate denials of medical necessity.

§137.100(d) and (f): Commenter recommends the deletion of subsections (d) and (f) so that all health care rendered within the treatment guidelines is considered reasonable and appropriate. Commenter believes the provisions of subsections (d) and (f) are contrary to legislative intent as the rationale behind HB 7's requirement in §413.011 of the Labor Code is to adopt treatment guidelines that provide the workers' compensation system with a communication tool whereby both health care providers and insurance carriers would have a mutual understanding that health care provided within the guidelines is considered appropriate and medically necessary. Commenter states the proposed rules increase the administrative burden of the health care provider. This burden is exacerbated by the ability of the insurance carrier to deny on relatedness and the inability of these rules to address compensability issues. This will result in more health care providers leaving the workers' compensation system.

Agency Response: The Division disagrees that subsections (d) and (f) are contrary to legislative intent. However, proposed subsection (d) is deleted from this rule and clarifying language is added to §137.300 to specify the requirements of treatment planning. As a result of that deletion, subsection (f) is now subsection (e). Although care provided within the guidelines is presumed to be reasonable, renumbered subsection (e) identifies that this is a rebuttable presumption based on the specific facts of the claim. Not all injures will need all care identified in the guidelines and some claims may need treatments or services not identified or in excess of the guidelines. The Division notes that the disability management rules have not been developed to deal with compensability or extent issues that are addressed in other Division rules. The Division believes adoption and implementation of the disability management concept and associated rules will increase communication opportunities for system participants, bring structure and certainty to the process, and ultimately decrease administrative burdens for system participants.

§137.100(d): Commenters recommend deleting subsection (d), including the deletion of the reference to subsection (d) in subsection (f). As the proposed rules already presume that all treatment according to the treatment guidelines are reasonable and necessary, commenters state that there is no reason to permit the medical provider to submit a request for preauthorization of a treatment plan within treatment guidelines. Commenters believe that submission of a treatment plan for services presumed to be "reasonable" and "reasonably required" is duplicative and adds unnecessary costs and time to stakeholders for the preauthorization process, retrospective audit for preauthorization validation, increased use of the reconsideration process, and increased medical dispute resolution costs, including IRO fees. Section 137.100(g) and §137.300(a) include provisions that address when treatment plans are required for submission to the insurance carrier for a medical necessity determination. Commenters further opine that health care providers are afforded resolution of conflicts under Division rules §§133.305, 133.307, 133.308, 134.650, and 134.600(r). A commenter suggests this rule provision will increase the number of medical disputes and undermine the treatment guideline by providing for a back-door through which a health care provider can obtain a prospective guarantee of payment of medical bills.

Agency Response: The Division disagrees that proposed subsections (d) and (f) are duplicative of other rule provisions. However, proposed subsection (d) is deleted from this rule and clarifying language is added to §137.300 to specify the requirements of treatment planning. Although care provided within the guidelines is presumed to be reasonable, subsection (e) identifies that this is a rebuttable presumption based on the specific facts of the claim. Not all injuries will need all care identified in the guidelines and some claims may need treatments or services not identified or in excess of the guidelines. Although proposed subsection

(d) is deleted and additional language is added to §137.300, the Division disagrees that this provision would be duplicative. This approach prevents unnecessary care and overutilization and insulates health care providers from the cost of providing services that the insurance carriers deem not medically necessary. The Division notes that language has been added to §137.300 to clarify when treatment within the guidelines should be included in a treatment plan.

§137.100(e): Commenter recommends that if treatment is provided in excess or beyond the scope of the adopted treatment guidelines, then the health care provider should be afforded a peer-to-peer interview with the insurance carrier's doctor within 24 hours.

Agency Response: The Division disagrees that additional direction is required regarding the preauthorization process. Peer-to-peer reviews are accounted for in §134.600. In addition, the time frames established in §134.600 are consistent with Insurance Code, Article 21.58A.

§137.100(e): Commenter expresses concern that the rule as proposed does not explicitly clarify how it dovetails with the preauthorization rule 134.600. Unless clarified, confusion is going to arise about when the treatment guideline rule or the preauthorization rule takes precedence.

Agency Response: The Division notes the commenter's concern and clarifies that details related to treatment planning in proposed §137.100 are deleted, and additional language regarding the relationship between preauthorization, treatment guidelines and treatment planning is added to §137.300.

§137.100(e)(2): Commenter requests clarification as to whether the term "treatment plan" is actually the intended term, or if the subsection refers to any and all services preauthorized in accordance with §134.600.

Agency Response: The Division notes that subsections (d) and (e) are changed to clarify which services an insurance carrier is liable for in excess of the Division treatment guidelines.

§137.100(e): Commenter recommends a new subsection (e) be added, with subsequent subsection re-numbering, to read, "The insurance carrier may not deny payment for health care services delivered in accord with treatment guidelines defined in subsection (a) of this section or an approved treatment plan as defined in §137.300, relating to Treatment Planning."

Agency Response: The Division declines to make the change. Although care within the guidelines is presumed reasonable and reasonably required, it is unlikely that all care within the guidelines will be medically necessary or required in each specific case. The treatment guideline rule allows the insurance carrier, when appropriate, to deny payment for care that is not medically necessary even though the care was included in the guideline. That denial of payment must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017. The Division notes that preauthorized care, including preauthorized treatment plans, are not subject to retrospective review of medical necessity. However, other factors, such as compensability or compliance with other billing requirements, could result in denial of reimbursement.

§137.100(f): Commenter states the rules only require the denying party to reference the source of their denial by simply stating their denial is based on ODG guidelines without being required to identify the specific component of the guidelines alluded to. Commenter states the main problem anticipated is that whatever guidelines are adopted, they will be used in the context of denying treatment.

Agency Response: The Division notes that division rules related to medical billing and reimbursement identify the specific requirements for denial of medical bills. The adopted guidelines establish an initial framework for reasonably required medical care. Although use of guidelines may result in denial of some services, and subsequently, some related medical necessity disputes, the adopted treatment guidelines provide a consistent benchmark for system participants. Overall, adoption of the disability management rules facilitates communication between system participants resulting in improved return to work outcomes.

§137.100(f): Commenter recommends the rules clearly define the responsibility of any reviewing physician to ensure all appropriate medical records are obtained, and states the rules are not sufficiently strong enough when addressing this issue. Commenter recommends the entity denying the recommendations of the orthopedic surgeon should be required to be a licensed practicing orthopedic surgeon in Texas, who is an active fellow of AAOS. This concept should apply at all levels of any appeals process.

Agency Response: The Division declines. Standards related to the review of proposed medical care and retrospective review of medical care are already defined in the Insurance Code and Division rules, therefore, no additional clarification is needed. Insurance Code 21.58A includes specific requirements for peer-to-peer reviews.

§137.100(f): Commenter opines that a doctor who performs as a patient advocate in initiating medical necessity appeals should not be penalized by having to pay the IRO fee. Commenter further objects to allowing an insurance carrier's critique of the patient's case and subsequently identifying new issues of contention. Labor Code §413.031 relating to Medical Dispute Resolution establishes which party in a medical necessity dispute is responsible for the IRO fee.

Agency Response: The Division recognizes the commenter's concern but notes that these issues are outside the scope of this rule making initiative.

§137.100(f): Commenter recommends a revision to add subsection (e) after the reference to subsection (d) otherwise, insurance carriers may retroactively deny services even if they have been preauthorized or rendered in an emergency.

Agency Response: The Division declines to make the recommended change. However, proposed subsection (d) is deleted from this rule. Further, the Division clarifies that services preauthorized in accordance with §134.600 are not subject to retrospective review of medical necessity as noted in Labor Code §413.014.

§137.100(f): Commenter recommends adding the words "in excess of treatment guidelines and..." Commenter additionally recommends the deletion of the rest of the sentence referencing subsection (d).

Agency Response: The Division declines to make the recommended change, however proposed subsection (d) is deleted. Additionally, the Division clarifies that proposed subsection (f) (adopted subsection (e)) establishes that the insurance carrier may retrospectively review health care provided within the treatment guidelines unless it has been preauthorized or voluntarily

certified. Health care that exceeds the treatment guidelines is required to be preauthorized in accordance with §134.600.

§137.100(f): Commenters recommend deleting the following language from subsection (f): "...not preauthorized under subsection (d) of this section" and "...that outweighs the presumption of reasonableness established by Labor Code §413.017," in order to provide consistency with the recommendation to delete subsection (d).

Agency Response: The Division declines to make the recommended changes. Subsection (d) as proposed is deleted and new subsection (d) pertains to the insurance carriers' liability for certain health care. The Labor Code §413.017 establishes the presumption of reasonableness. Deletion of the language "...that outweighs the presumption of reasonableness established by Labor Code §413.017," would effectively negate the presumption of reasonableness established by the Labor Code.

§137.100(f): Commenters recommend the following phrase addition to the last sentence, "...or that demonstrates that the claimant has not benefited from the same or similar type of treatment in the past."

Agency Response: The Division declines to make the recommended change. Medical necessity is established on a case-by-case basis consistent with the principles of evidence-based medicine. A specific blanket statement as indicated is potentially contrary to the concept of evidence-based medicine as applied to an individual case.

§137.100(f): Commenters suggest the proposed rule may be so restrictive that insurance carriers may not have the tools to combat medical billing, over-utilization, fraud and abuse as the proposal potentially prohibits the insurance carrier from denying payment in claims when the claimant may have fully recovered from the compensable injury prior to the rendition of care within the guidelines.

Agency Response: The Division disagrees. Adopting the disability management concept leaves all the tools previously available to insurance carriers in place. Further, these disability management rules provide for an improved communication process for health care providers and insurance carriers to discuss an injured employees' health care and offer insurance carriers excellent tools to evaluate the utilization of health care. In addition, subsection (e) allows an insurance carrier to retrospectively review health care provided within the treatment guidelines. The Division is committed to removing fraud and abuse from the workers' compensation system but is equally committed to safeguarding necessary medical care for injured employees.

§137.100(h): Commenter recommends changes to subsection (h) to read, "the insurance carrier shall not deny treatment 'or payment' solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or the Division treatment protocols."

Agency Response: The Division declines to make this recommendation. The recommended language is unnecessary and potentially confusing. Addition of the suggested language could lead to confusion distinguishing between medical and fee disputes. Although treatment denied in accordance with a treatment guideline leads to denial of payment, the dispute should be processed as a medical necessity dispute and proceed according to §133.308.

§137.100(i): Commenters support the effective date of January 1, 2007, provided at least 45 days to implement the new treatment paradigm is available for system and process changes to occur that are necessary for compliance.

Agency Response: The Division agrees. The implementation date for treatment guidelines has been changed to May 1, 2007.

§137.300: Commenters recommend added language to specify the information that should be included on a treatment plan submitted by the treating doctor and a requirement for a standard format with the inclusion of all diagnoses and associated treatments. A commenter recommends the treatment plan should identify co-morbid conditions that affect the treatment being requested for the injury. Commenter makes an additional recommendation to add language to §137.300 to specify the information that should be included on a treatment plan in a standardized format with all diagnoses and associated treatments.

Agency Response: The Division declines to make the recommended changes. Treatment plans submitted as a result of this section are required to comply with the requirements of §134.600, which establishes the components of a complete preauthorization request. The request shall include information to substantiate the medical necessity of the health care requested. Additionally, a specific Division form is unnecessary as long as the requirements of §134.600(f) are met.

§137.300: Commenter understands and agrees that there should be a global treatment plan created and overseen by the treating physician.

Agency Response: The Division agrees and clarifies that only required treatment plans as identified in subsection (a) must be coordinated by the treating doctor.

§137.300: Commenter states in the initial phase, health care providers with a proven track record of achieving desired outcomes should be allowed to pursue treatment plans that have proven to be effective, particularly for patients identified as at risk for delayed recovery. Commenter explains such necessity may modestly exceed the guidelines.

Agency Response: The Division disagrees. Health care outside the guidelines requires preauthorization and in specified circumstances treatment planning through the preauthorization process. This increases the opportunity for communication between health care providers and insurance carriers, minimizes over utilization of services and adds to surety of payment for health care providers.

§137.300(a): Commenters recommend a health care provider submit a treatment plan only upon the request of the insurance carrier or the insurance carrier's utilization review program. A commenter recommends the timeline be established at 20 days for the treatment plan submission. Another commenter recommends a treatment plan be required once a claim becomes at risk for excessive lost time and poor return to work and recovery outcomes. The process should be used prudently on those claims at greatest risk for poor outcomes since processing treatment plans is burdensome to the system participants.

Agency Response: The Division disagrees. The intent of the disability management rules is to provide tools for the efficient utilization of health care. In order for these tools to be used consistently, criteria for the use of treatment planning is established in these rules. Treatment planning, when conducted only at the request of the insurance carrier, would allow for vastly different standards between insurance carriers and potentially lead to additional administrative costs and confusion for health care providers. This would defeat the purpose of establishing bench-

marks for consistent use throughout the system and hinder efforts to compare and identify high performers in the system.

§137.300(a): Commenters recommend a limit to the specified period of time that can be covered by a treatment plan. A commenter recommends rule clarity as to the length of time the treatment plan is to cover with caution and consideration given to the expense of processing preauthorization requests. Another commenter recommends that both this section and §134.600 should state that durations for treatment plans be no more than 30 days, as commenter believes a treatment plan should be limited to a specified time frame. Commenter notes that §134.600(g) provides for a sixty-day time frame to request health care for treating an injury or diagnosis that is not accepted by the insurance carrier in accordance with Labor Code §408.0042.

Agency Response: The Division agrees that treatment plans should cover a specified time period and the language has been changed to indicate that treatment plans shall cover health care treatments and services to be provided to the injured employee for a minimum of 30 days. Insurance carriers and health care providers may negotiate a longer time frame that is appropriate to the specific case as part of the treatment plan through the preauthorization process. For example, a treatment plan covering an extended period of time may be appropriate for a catastrophic injury. Communication between insurance carriers, health care providers and injured employees should lead to an effective treatment planning process minimizing inappropriate requests and/or denials. The Division disagrees that the time period for treatment plans should mirror §134.600(g). The treatment plans addressed by §134.600(g) serve a specific purpose related to compensability issues and the dispute resolution time frames.

§137.300(a)(1): Commenter recommends the use of a lost time parameter as criteria for requiring treatment planning for at risk claims. Additionally, commenter states the other criteria for requiring treatment planning are reasonable.

Agency Response: The Division agrees that the disability management and the treatment planning process would benefit from the inclusion of a time parameter as a trigger for treatment planning. The rule is changed to establish a treatment planning link to the optimum days listed in adopted §137.10 or 60 days from the date of injury, whichever is greater.

§137.300(a): Commenter states the rule lacks details pertaining to amended or modified treatment plans.

Agency Response: The Division disagrees that additional explanation is necessary because changes or extensions of care in a preauthorized treatment plan are addressed through the concurrent review provisions of §134.600(q)(6).

§137.300(a): Commenter recommends minimal duration times for specific treatment plans based on aging of claims, but allowing flexibility between treating doctor and payor to ease negotiations.

Agency Response: The Division agrees. The language has changed to require a treatment plan for a minimum of 30 days. Insurance carriers and health care providers may negotiate a longer duration for a treatment plan as part of the preauthorization process.

§137.300(a): Commenter recommends the development of an accompanying treatment planning form, which could be a modification of the DWC Form-73, to include specific treatment recommendations, CPT codes, and appropriate time frames. Commenter states this would allow for a standardized information set and format to simplify and ease the process.

Agency Response: The Division declines to develop an additional Division form for the submission of treatment plans. Treatment plans submitted as a result of this section are required to comply with the requirements of §134.600 and the new sections.

§137.300(a): Commenters recommend that in addition to specifying who is responsible, the rule specify deadlines for the submission of the treatment plan, and if the treatment plan is not timely submitted, then allow the insurance carrier to request a designated doctor exam for purposes of addressing a treatment plan.

Agency Response: The Division declines because additional language would be duplicative of the provisions of §134.600, which establishes the required elements and time frames for submission of a preauthorization request. Treatment plans are submitted as preauthorization requests. Other Division rules allow the insurance carrier the option of requesting designated doctor evaluations of medical care and do not require a specified time frame.

§137.300(a): Commenters recommend the following language, "...the treating doctor is required to submit written treatment plans to the insurance carrier within ten (10) working days of receipt of a written request from the insurance carrier when..." Commenters suggest this approach would require the treating doctor to submit a treatment plan as specified in subsection (a)(1) - (3) only if the insurance carrier has requested a treatment plan in writing. Commenters state a treatment plan is not necessary in all claims in which a diagnosis is not included in the treatment or return to work guidelines, especially if there is not sufficient injury severity to support the time and expense of developing a treatment plan.

Agency Response: The Division declines to make the recommendation to require the treating doctor to submit a treatment plan only if the insurance carrier requests a treatment plan in writing. The change would require the initiation of the treatment planning process only on the request of an insurance carrier. Currently, the Division rejects this concept because treatment planning, when conducted only at the request of the insurance carrier, would allow for vastly different standards between insurance carriers and potentially lead to additional administrative costs and confusion for health care providers. This would defeat the purpose of establishing benchmarks for consistent use throughout the system and hinder efforts to compare and identify high performers in the system. The Division agrees that a treatment plan may not be required in all instances. With the adoption of treatment guidelines a majority of injuries and treatment for injuries that resolve quickly are likely addressed within the treatment guidelines and would not require a treatment plan. Additionally, language has been changed to require treatment plans in only certain circumstances.

§137.300(a): A commenter recommends the deletion of the reference to diagnosis not addressed by the return to work guidelines in subsection (a)(2). The commenter states a lack of diagnosis being included in the Division's return to work guidelines is irrelevant when addressing the appropriateness and medical necessity of health care in the Texas Workers' compensation system.

Agency Response: The Division agrees and the reference to diagnosis not included in the return to work guidelines is deleted from subsection (a).

§137.300(a): Commenter recommends adding in subsection (a) an additional requirement stating, "treatment plans are required when treatment is outside the optimum return to work guidelines are exceeded."

Agency Response: The Division agrees that criteria for required treatment plans should include a lost time reference and subsection (a) is changed to link to the adopted return to work guidelines.

§137.300(a): Commenter recommends substitutions of "reasonably" for "all" to subsection (a) to read, "A treatment plan shall include the identification of 'reasonably' anticipated health care and treatment and services to be provided to the injured employee for a specified period of time."

Agency Response: The Division agrees in concept and the language has been changed to incorporate the language all reasonably anticipated into subsection (a).

§137.300(a): Commenter recommends amended language to also state that treatment planning rules have been adopted to improve the quality of treatment provided to injured employees and improve return to work outcomes in the Texas workers' compensation system, and to confirm that the rules do not apply to claims subject to workers' compensation health care networks under Chapter 1305 of the Insurance Code.

Agency Response: The Division declines to make the recommended change, as similar language is already included in §137.1. The Division declines to make the modifications to the rule that reiterates the provisions of the Labor and Insurance Codes. Labor Code, §413.011(g) provides that rules adopted relating to disability management do not apply to claims subject to workers' compensation networks. Workers compensation networks are required to adopt their own treatment guidelines, return-to work guidelines, and individual treatment protocols, pursuant to Insurance Code §1305.304. Based on the specificity of the Labor Code and Insurance Code provisions, the Division believes it is unnecessary to restate such provisions in the adopted rules.

§137.300(b): Commenters recommend the deletion of subsection (b) and any references to it in the remaining, re-numbered subsections. Subsection (b) as proposed would be an administrative burden for system participants. Voluntary certification, preauthorization, and concurrent review issues would be intermingled in a single treatment plan, because this treatment is already outside the treatment guidelines. Commenters state the recommended deletion of subsection (b) would be consistent with other recommended section and subsection deletions that pertain to treatments and services or treatment plans that are presumed to be reasonable. Submission of a treatment plan for services that are presumed to be "reasonable" and "reasonably required" adds unnecessary requirements and costs to stakeholders. A commenter opines that §137.100(g) and §137.300(a) include provisions that address when treatment plans are required for submission to the insurance carrier for a medical necessity determination.

Agency Response: The Division agrees to change subsection (b) and the permissive language regarding treatment planning for treatments and services within the Division's treatment guideline is deleted.

§137.300(c): Commenter states that when an orthopedic surgeon is not defined as the treating doctor, then communication of any denials and subsequent appeals bypass the orthopedic surgeon. By rule, the commenter notes, the insurance carrier only needs to communicate with the treating doctor. Commenter additionally opines that the control and management of a patient post-operatively should be clearly defined as the responsibility of the surgeon and not abrogated to the treating doctor.

Agency Response: The Division disagrees that communication of any denials and subsequent appeals will bypass the health care provider if that health care provider is not also the treating doctor that submits the treatment plan to the insurance carrier. However, the adopted rule added language in subsection (e) to facilitate communication between the necessary parties and provides that the treatment plan include the contact information of the health care providers involved in the delivery of care proposed within the treatment plan and requires the treating doctor to inform the health care provider(s) of the approval or denial of the treatment plan. In addition, prior to an adverse determination by a utilization review agent and subject to notice requirements, the health care provider who orders the service submitted by the treating doctor in the treatment plan, is afforded a reasonable opportunity to discuss the plan of treatment for the injured employee with the appropriate doctor or health care provider performing the review in accordance with Insurance Code Article 21.58 A §4(k), recodified as §4201.206.

§137.300(c): Commenters recommend changing the rule from treating doctor to requesting doctor. Commenters state that treating doctors may not be able to adequately support and defend preauthorization requests for specialty treatment, thereby, delaying necessary treatment to injured employees. Commenters state this approach was previously required in the Texas workers' compensation system and it created extreme periods of delayed recovery, inefficiencies, and disputes. A commenter states this provision is another administrative burden upon the treating doctor and, therefore, recommends striking the language requiring a treating doctor to submit the treatment plan. Another commenter notes the proposed rule appears to conflict with multiple utilization review regulations within the Division and TDI requiring review of service by same licensed type and/or specialty as the requestor.

Agency Response: The Division declines to make the recommended revision. The treating doctor is responsible for efficient and cost-effective utilization of health care as outlined in the Labor Code §§408.021(c), 408.023(l), and 408.025(c). In order to fulfill this responsibility, treating doctors must be proactively involved in the development and support of services and treatments recommended for the early and appropriate return to work of injured employees. The Division disagrees that there is a conflict as to §21.58A of the Insurance Code. Insurance Code Article 21.58A §4(i), recodified as §4201.153(d), provides that denials of treatment must be referred to an appropriate physician, dentist, or other health care provider to determine medical necessity. Therefore, the statute requires review of service by an appropriate health care provider, not necessarily review by a health care provider with the same type of license and/or specialty practice. In addition, prior to an adverse determination by a utilization review agent and subject to notice requirements, the health care provider who ordered the service submitted by the treating doctor in the treatment plan, is afforded a reasonable opportunity to discuss the plan of treatment for the injured employee with the appropriate doctor or health care provider performing the review in accordance with Insurance Code Article 21.58 A §4(k), recodified as §4201.206.

§137.300(c): Commenters recommend revising the paragraph and offer suggested language so that the treating doctor is still required to express concurrence with the plan in writing, but once obtained, the health care provider actually rendering the service may submit their own plan directly to the insurance carrier and be the health care provider conferring with a peer if necessary to discuss the treatment plan. One commenter offered the following recommended revision, "When a health care provider develops a treatment plan pursuant to subsection (a) or (b) of this section, it shall be submitted to the treating doctor who will indicate approval of the plan in writing. The treating doctor or his representative shall then submit the approved plan to the insurance carrier to be processed as a preauthorization request pursuant to §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care)." Another commenter's recommendation is to seek the treating doctor's sign-off on the proposed treatment plan that the physical therapist/occupational therapist establishes, and then that treatment plan is submitted to the insurance carrier for approval.

Agency Response: The Division declines to make the recommended changes. §§401.011, 408.021, 408.023, and 408.025 of the Labor Code detail the responsibilities of a treating doctor. These responsibilities include the efficient management of medical care, the efficient utilization of health care, and except in an emergency, the responsibility to approve or recommend all health care. The Labor Code clearly intends the treating doctor to be the focal point for health care provided to an injured employee. The treatment planning process is the tool that facilitates the ability of the treating doctor to meet his or her obligations under the Labor Code. Distributing these responsibilities to other system participants undermines the intent of the Labor Code.

§137.300(c): Commenter recommends deleting the reference to subsections (a) and (b) as this would be consistent with other recommended section and subsection changes/deletions. Commenter asserts it is appropriate for the treating doctor to be the point of contact for treatment plans with the insurance carriers as this is consistent with their gatekeeper role in the workers' compensation system.

Agency Response: The Division acknowledges the recommendation and notes that the recommendation is addressed through the revision of the section. The section is changed and renumbered to clarify the instances requiring treatment planning and the services required for inclusion in a treatment plan.

§137.300(c): Commenter recommends increasing the preauthorization response time to five days for treatment planning, instead of the current three-day response time in §134.600. Commenter recommends the development of different preauthorization time frame standards for evaluating a comprehensive treatment plan. The Division should seek additional appropriate stakeholder input on the time frames because the time frames in the preauthorization rule are not sufficient for the complexities of a treatment plan.

Agency Response: The Division notes that a revision to the time frames included in §134.600 are outside the scope of this rule. Addition of time frames to this rule would create a bifurcated preauthorization process and likely lead to additional administrative burdens for system participants. Any changes to the time frames included in §134.600 will be addressed through a separate rule making activity which would include stakeholder input.

§137.300(c): Commenter recommends a revision to allow the health care provider to submit a physician approved treatment plan or physician authorization directly to the insurance carrier; or require the insurance carrier to supply preauthorization to the physician and the involved health care providers individually. Commenter states §137.300(c) as proposed creates an undue burden on the treating doctor and causes delays in receiving timely care.

Agency Response: The Division declines to make the recommended changes. Labor Code §§401.011, 408.021, 408.023, and 408.025 detail the responsibilities of a treating doctor. These responsibilities include the efficient management of medical care, the efficient utilization of health care, and except in an emergency, the responsibility to approve or recommend all health care. The Labor Code clearly intends the treating doctor to be the focal point for health care provided to an injured employee. The treatment planning process is the tool that facilitates the ability of the treating doctor to meet these obligations under the Labor Code. Distributing these responsibilities to other system participants undermines the Labor Code. The Division also disagrees that development of a treatment plan will delay timely care. Treatment planning should lead to the systematic delivery of care, more efficient utilization of services and improved return to work outcomes for injured employees.

§137.300(c): Commenter seeks clarification as to whether the treatment plans must be approved in their entirety as submitted by the treating doctor.

Agency Response: The Division notes that a required treatment plan is on the list of items requiring preauthorization. Criteria for submitting and processing preauthorization requests is established in §134.600.

§137.300(c): Commenter recommends the treating doctor be designated as a gatekeeper or coordinator of care and be reimbursed for those services. Commenter states that if there is an issue of the treating doctor wanting control and continuity of a patient, a copy of the treatment plan submitted to the insurance carrier could be required to be submitted to the treating physician simultaneously.

Agency Response: The Division agrees that the treating doctor has special responsibilities as required by the Labor Code and believes that the disability management concept and associated rules facilitate the treating doctor's ability to successfully comply with those responsibilities. Issues related to reimbursement are not directly addressed in this rule making activity but are included in §134.202 (relating to Medical Fee Guideline).

§137.300(d): Commenter supports the effective date provided there is at least 45 days to implement the new treatment paradigm for system and process changes to occur that are necessary for compliance.

Agency Response: The Division agrees and §§ 137.10, 137.100 and 137.300 are changed to reflect an implementation date of May 1, 2007.

For: Work Loss Data Institute.

For, with changes: Individuals, a Legislator, American College of Occupational and Environmental Medicine, Positive Health Management, Healthcare Consulting Associates, State Office of Risk Management, American Airlines, Texas Mutual Insurance Company, Zenith Insurance Company, American Academy of Orthopaedic Surgeons, Somi Healthlink, Reed Group, Ltd., Healthsouth Corporation, Texas Association of School Boards, Insurance Council of Texas, Concentra, Inc., American Insurance Association, Flahive, Ogden & Latson, Law Offices of W.J.

Bill Morris, WORK REHAB, Texas Medical Association, BIOMET, Texas Association of Business, Texas Physical Therapy Association, Office of Injured Employee Council, Physicians Cooperative of Texas, and Texas Orthopaedic Association.

Against: Individuals, Texas Association of Neurological Surgeons, and the Texas Spine Society.

Neither For nor Against: Fair Isaac Corporation and Work-STEPS.

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §137.1

The new section is adopted under Labor Code §§413.011(e), 413.011(g), 401.011, 413.021, 409.005, 408.023, 408.025, 413.017, 413.018, 413.013, 408.021, 402.00111, and 402.061. Section 413.011(e) provides that the Commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols with specific criteria for such adoption. Section 413.011 (g) provides that the Commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. Section 401.011 contains definitions used in the Texas workers' compensation system (in particular, §401.011(18-a), the definition of "evidence-based medicine," §401.011(22-a), the definition of "health care reasonably required" and §401.011(42), the definition of "treating doctor"). Section 413.021 requires an insurance carrier to provide the employer with return-to-work coordination services as necessary to facilitate an employee's return to employment. Section 409.005 provides the procedure for filing a report of injury, the format to be used, authorizes the adoption of rules regarding the information that must be included in the report, and requires the employer to notify the employee, the treating doctor, and the insurance carrier of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. Section 408.023 requires the Division to develop a list of doctors licensed in Texas who are approved to provide health care services under the Workers' Compensation Act and authorizes the Commissioner to adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor. Section 408.025 authorizes the Commissioner by rule to adopt requirements for reports and records, and provides that the treating doctor is responsible for maintaining efficient utilization of health care. Section 413.017 provides that certain medical services are presumed reasonable. Section 413.018 provides that the commissioner by rule shall provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded and the Division shall review the medical treatment provided in a claim that exceeds the guidelines and may take appropriate action to ensure that necessary and reasonable care is provided. Section 413.013 authorizes the Commissioner by rule to establish programs for prospective, concurrent, and retrospective review and resolution of disputes regarding health care treatments and services, for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments to ensure that the medical policies or guidelines are not exceeded, to detect practices and patterns by insurance carriers, and to increase the intensity of review for compliance with the medical policies or fee guidelines. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed (specifically health care that enhances the ability of the employee to return to or retain employment) and provides that, except in an emergency, all health care must be approved or recommended by the employee's treating doctor. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the Commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§137.1. Disability Management Concept.

(a) Disability management is a process designed to optimize health care and return to work outcomes for injured employees to avoid delayed recovery in the Texas Workers' Compensation System.

(b) This chapter is designed to provide disability management tools, such as treatment and return to work guidelines, treatment protocols, treatment planning, and case management to benchmark, manage, and achieve improved outcomes. The Division may use these tools for the following purposes, including, but not limited to:

(1) resolving income benefit disputes;

(2) resolving medical benefit disputes;

(3) establishing performance-based tiers;

(4) defining performance-based incentives;

(5) determining sanctions or penalties;

(6) performing medical quality reviews; or

(7) assessing other matters deemed appropriate by the Commissioner of Workers' Compensation.

(c) The Division will utilize this chapter to implement and interpret specific provisions contained in Labor Code §413.011(a) and (e), and this chapter takes precedence over any conflicting payment policy provisions adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program.

(d) Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to Medical Dispute Resolution by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over adopted treatment guidelines, treatment protocols, treatment planning and Medicare payment policies.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 29, 2006.

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Norma Garcia
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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For further information, please call: (512) 804-4288

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SUBCHAPTER B. RETURN TO WORK

28 TAC §137.10

The new section is adopted under Labor Code §§413.011(e), 413.011(g), 401.011, 413.021, 409.005, 408.023, 408.025, 413.017, 413.018, 413.013, 408.021, 402.00111, and 402.061. Section 413.011(e) provides that the Commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols with specific criteria for such adoption. Section 413.011(g) provides that the Commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. Section 401.011 contains definitions used in the Texas workers' compensation system (in particular, §401.011(18-a), the definition of "evidence-based medicine," §401.011(22-a), the definition of "health care reasonably required" and §401.011(42), the definition of "treating doctor"). Section 413.021 requires an insurance carrier to provide the employer with return-to-work coordination services as necessary to facilitate an employee's return to employment. Section 409.005 provides the procedure for filing a report of injury, the format to be used, authorizes the adoption of rules regarding the information that must be included in the report, and requires the employer to notify the employee, the treating doctor, and the insurance carrier of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. Section 408.023 requires the Division to develop a list of doctors licensed in Texas who are approved to provide health care services under the Workers' Compensation Act and authorizes the Commissioner to adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor. Section 408.025 authorizes the Commissioner by rule to adopt requirements for reports and records, and provides that the treating doctor is responsible for maintaining efficient utilization of health care. Section 413.017 provides that certain medical services are presumed reasonable. Section 413.018 provides that the commissioner by rule shall provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded and the Division shall review the medical treatment provided in a claim that exceeds the guidelines and may take appropriate action to ensure that necessary and reasonable care is provided. Section 413.013 authorizes the Commissioner by rule to establish programs for prospective, concurrent, and retrospective review and resolution of disputes regarding health care treatments and services, for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments to ensure that the medical policies or guidelines are not exceeded, to detect practices and patterns by insurance carriers, and to increase the intensity of review for compliance with the medical policies or fee guidelines. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed (specifically health care that enhances the ability of the employee to return to or retain employment) and provides that, except in an emergency, all health care must be approved or recommended by the employee's treating doctor. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the Commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§137.10. Return to Work Guidelines.

(a) Insurance carriers, health care providers, and employers shall use the disability duration values in the current edition of *The Medical Disability Advisor, Workplace Guidelines for Disability Duration*, excluding all sections and tables relating to rehabilitation, (MDA), published by the Reed Group, Ltd. (Division return to work guidelines), as guidelines for the evaluation of expected or average return to work time frames.

(b) Information on how to obtain or inspect copies of the Division return to work guidelines may be found on the Division's website: *www.tdi.state.tx.us*.

(c) The Division return to work guidelines provide disability duration expectancies. The Division return to work guidelines shall be presumed to be a reasonable length of disability duration and shall be used by:

(1) health care providers to establish return to work goals or a return to work plan for safely returning injured employees to medically appropriate work environments;

(2) insurance carriers as a basis for requesting a designated doctor examination to resolve an issue regarding an injured employee's ability to return to work as well as a basis to initiate case management and to refer an injured employee to vocational rehabilitation providers; and

(3) employers, insurance carriers, health care providers, and injured employees to facilitate and improve communications among the parties regarding the return to work goals or plans established by health care providers.

(d) The health care provider, insurance carrier, employer, and Division may consider co-morbid conditions, medical complications, or other factors that may influence medical recoveries and disability durations as mitigating circumstances when setting return to work goals or revising expected return to work durations and goals.

(e) Disability duration values in the guidelines are not absolute values and do not represent specific lengths or periods of time at which an injured employee must return to work; the values represent points in time at which additional evaluation may take place if full medical recovery and return to work have not occurred. System participants may, however, determine additional evaluation is appropriate at any time during a claim. The disability duration values depict a continuum from the minimum time to the maximum time for most individuals to return to work following a particular injury. An insurance carrier may request additional return to work information from a health care provider at any time. An insurance carrier may not use the Division return to work guidelines as the sole justification or the only reasonable grounds for reducing, denying, suspending or terminating income benefits to an injured employee.

(f) For all diagnoses or injuries that are not addressed by the Division return to work guidelines, system participants shall establish disability duration parameters and return to work goals in accordance with the principles of evidence-based medicine as defined by Labor Code §401.011(18-a).

(g) This section is effective on or after May 1, 2007.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 29, 2006.

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Norma Garcia
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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SUBCHAPTER C. TREATMENT GUIDELINES

28 TAC §137.100

The new sections are adopted under Labor Code §§413.011(e), 413.011(g), 401.011, 413.021, 409.005, 408.023, 408.025, 413.017, 413.018, 413.013, 408.021, 402.00111, and 402.061. Section 413.011(e) provides that the Commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols with specific criteria for such adoption. Section 413.011(g) provides that the Commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. Section 401.011 contains definitions used in the Texas workers' compensation system (in particular, §401.011(18-a), the definition of "evidence-based medicine," §401.011(22-a), the definition of "health care reasonably required" and §401.011(42), the definition of "treating doctor"). Section 413.021 requires an insurance carrier to provide the employer with return-to-work coordination services as necessary to facilitate an employee's return to employment. Section 409.005 provides the procedure for filing a report of injury, the format to be used, authorizes the adoption of rules regarding the information that must be included in the report, and requires the employer to notify the employee, the treating doctor, and the insurance carrier of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. Section 408.023 requires the Division to develop a list of doctors licensed in Texas who are approved to provide health care services under the Workers' Compensation Act and authorizes the Commissioner to adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor. Section 408.025 authorizes the Commissioner by rule to adopt requirements for reports and records, and provides that the treating doctor is responsible for maintaining efficient utilization of health care. Section 413.017 provides that certain medical services are presumed reasonable. Section 413.018 provides that the commissioner by rule shall provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded and the Division shall review the medical treatment provided in a claim that exceeds the guidelines and may take appropriate action to ensure that necessary and reasonable care is provided. Section 413.013 authorizes the Commissioner by rule to establish programs for prospective, concurrent, and retrospective review and resolution of disputes regarding health care treatments and services, for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments to ensure that the medical policies or guidelines are not exceeded, to detect practices and patterns by insurance carriers, and to increase the intensity of review for compliance with the medical policies or fee guidelines. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed (specifically health care that enhances the ability of the employee to return to or retain employment) and provides that, except in an emergency, all health care must be approved or recommended by the employee's treating doctor. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the Commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§137.100. Treatment Guidelines.

(a) Health care providers shall provide treatment in accordance with the current edition of the *Official Disability Guidelines - Treatment in Workers' Comp*, excluding the return to work pathways, (ODG), published by Work Loss Data Institute (Division treatment guidelines), unless the treatment(s) or service(s) require(s) preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) or §137.300 of this title (relating to Required Treatment Planning).

(b) Information on how to obtain or inspect copies of the Division treatment guidelines may be found on the Division's website: *www.tdi.state.tx.us*.

(c) Health care provided in accordance with the Division treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

(d) The insurance carrier is not liable for the costs of treatments or services provided in excess of the Division treatment guidelines unless:

(1) the treatment(s) or service(s) were provided in a medical emergency; or

(2) the treatment(s) or service(s) were preauthorized in accordance with §134.600 or §137.300 of this title.

(e) An insurance carrier may retrospectively review, and if appropriate, deny payment for treatments and services not preauthorized under subsection (d) of this section when the insurance carrier asserts that health care provided within the Division treatment guidelines is not reasonably required. The assertion must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established by Labor Code §413.017.

(f) A health care provider that proposes treatments and services which exceed, or are not included, in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title, or may be required to submit a treatment plan in accordance with §137.300 of this title.

(g) The insurance carrier shall not deny treatment solely because the diagnosis or treatment is not specifically addressed by the Division treatment guidelines or Division treatment protocols.

(h) This section applies to health care provided on or after May 1, 2007.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Norma Garcia
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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SUBCHAPTER D. TREATMENT PLANNING

28 TAC §137.300

The new section is adopted under Labor Code §§413.011(e), 413.011(g), 401.011, 413.021, 409.005, 408.023, 408.025, 413.017, 413.018, 413.013, 408.021, 402.00111, and 402.061. Section 413.011(e) provides that the Commissioner by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols with specific criteria for such adoption. Section 413.011(g) provides that the Commissioner may adopt rules relating to disability management that are designed to promote appropriate health care at the earliest opportunity after the injury to maximize injury healing and improve stay-at-work and return-to-work outcomes through appropriate management of work-related injuries or conditions. Section 401.011 contains definitions used in the Texas workers' compensation system (in particular, §401.011(18-a), the definition of "evidence-based medicine," §401.011(22-a), the definition of "health care reasonably required" and §401.011(42), the definition of "treating doctor"). Section 413.021 requires an insurance carrier to provide the employer with return-to-work coordination services as necessary to facilitate an employee's return to employment. Section 409.005 provides the procedure for filing a report of injury, the format to be used, authorizes the adoption of rules regarding the information that must be included in the report, and requires the employer to notify the employee, the treating doctor, and the insurance carrier of the existence or absence of opportunities for modified duty or a modified duty return-to-work program available through the employer. Section 408.023 requires the Division to develop a list of doctors licensed in Texas who are approved to provide health care services under the Workers' Compensation Act and authorizes the Commissioner to adopt rules to define the role of the treating doctor and to specify outcome information to be collected for a treating doctor. Section 408.025 authorizes the Commissioner by rule to adopt requirements for reports and records, and provides that the treating doctor is responsible for maintaining efficient utilization of health care. Section 413.017 provides that certain medical services are presumed reasonable. Section 413.018 provides that the commissioner by rule shall provide for the periodic review of medical care provided in claims in which guidelines for expected or average return to work time frames are exceeded and the Division shall review the medical treatment provided in a claim that exceeds the guidelines and may take appropriate action to ensure that necessary and reasonable care is provided. Section 413.013 authorizes the Commissioner by rule to establish programs for prospective, concurrent, and retrospective review and resolution of disputes regarding health care treatments and services, for the systematic monitoring of the necessity of treatments administered and fees charged and paid for medical treatments to ensure that the medical policies or guidelines are not exceeded, to detect practices and patterns by insurance carriers, and to increase the intensity of review for compliance with the medical policies or fee guidelines. Section 408.021 provides that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed (specifically health care that enhances the ability of the employee to return to or retain employment) and provides that, except in an emergency, all health care must be approved or recommended by the employee's treating doctor. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the Commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§137.300. Required Treatment Planning.

(a) A treatment plan shall include the identification of all reasonably anticipated health care treatment and services to be provided to the injured employee for a minimum of 30 days. Treatment plans shall be consistent with the principles of evidence-based medicine and health care reasonably required as defined in Labor Code §401.011(18-a) and (22-a) and shall be submitted for preauthorization by the treating doctor. Treatment plans are required when:

(1) treatment or service is anticipated to exceed or is not included in Division treatment guidelines or Division treatment protocols in accordance with §137.100 of this title (relating to Treatment Guidelines); and the treatment or service will be provided after the greater of:

(A) 60 days from the date of injury; or

(B) the optimum days listed in §137.10 of this title (related to Return to Work Guidelines);

(2) a diagnosis is not included in Division treatment guidelines or Division treatment protocols; or

(3) deemed necessary by the Commissioner as a result of sanctions imposed in accordance with Labor Code §408.0231(e) and (f) and other relevant sections of this title.

(b) A treatment plan is not required for treatments and services within the Division treatment guidelines or Division treatment protocols unless the treatments or services are submitted as part of a required treatment plan in accordance with subsection (a) of this section.

(c) When a health care provider identifies treatments and services that require preauthorization in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care), the treatment or service may be submitted for preauthorization by a health care provider unless the health care is submitted as part of a treatment plan in accordance with subsection (a) of this section.

(d) When a health care provider develops a treatment plan pursuant to subsection (a) or (b) of this section, it shall be submitted by the treating doctor to the insurance carrier and processed as a preauthorization request pursuant to §134.600. If the health care provider is not the treating doctor and identifies services that require a treatment plan pursuant to subsection (a) of this section, the health care provider shall confer with the treating doctor to develop the required treatment plan in accordance with subsection (a) of this section.

(e) The treating doctor shall confer with the health care providers, insurance carriers, employers, or injured employees as necessary to develop the treatment plan. The treatment plan shall include the identity and contact information of the health care providers involved in the delivery of care proposed within the treatment plan.

(f) The treating doctor shall inform the parties identified in subsection (e) of this section of the approval or denial of the treatment plan.

(g) This section applies to health care provided on or after May 1, 2007.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 29, 2006.

TRD-200606919
Norma Garcia
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: January 18, 2007
Proposal publication date: September 1, 2006
For further information, please call: (512) 804-4288

REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Adopted Rule Review

Texas Youth Commission

Title 37, Part 3

Pursuant to Government Code §2001.039, the Texas Youth Commission files this notice of re-adoption for 37 TAC Chapter 91 (Program Services), Chapter 93 (Youth Rights and Remedies) and Chapter 95 (Youth Discipline). The proposed review was published in the November 24, 2006, issue of the *Texas Register* (31 TexReg 9623). No public comments were received regarding this review.

Except as noted below, the commission has determined that the reasons for adopting the rules contained in these chapters continue to exist and the rules are readopted without changes. Rules considered during this review may be subsequently revised in accordance with the Texas Administrative Procedure Act.

During the course of its review, the commission determined that the reason for adopting §91.1, concerning Daily Living, continues to exist but is addressed elsewhere in the commission's rules with more clarity and specificity. Therefore, the commission is proposing the repeal of this rule, as published in the Proposed Rules portion of this issue of the *Texas Register*.

This concludes the commission's review of Chapters 91, 93, and 95.

TRD-200606911
Neil Nichols
General Counsel
Texas Youth Commission
Filed: December 29, 2006

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IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Texas Building and Procurement Commission

Request for Proposals

The Texas Building and Procurement Commission (TBPC), on behalf of the Department of Family and Protective Services, announces the issuance of Request for Proposals (RFP) #303-7-10912. TBPC seeks a five year lease of approximately 5,248 square feet of office space in Lockhart, Caldwell County, Texas.

The deadline for questions is January 8, 2007 and the deadline for proposals is January 17, 2007 at 3:00 p.m. The award date is February 1, 2007. TBPC reserves the right to accept or reject any or all proposals submitted. TBPC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of a RFP. Neither this notice nor the RFP commits TBPC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting TBPC Purchaser Myra Beer at (512) 463-5773. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.tbpc.state.tx.us/bid_show.cfm?bidid=68562*.

TRD-200606899
Ingrid K. Hansen
General Counsel
Texas Building and Procurement Commission
Filed: December 27, 2006

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of January 1, 2007 - January 7, 2007 is 18% for Consumer[1]/Agricultural/Commercial[2]/credit thru $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of January 1, 2007 - January 7, 2007 is 18% for Commercial over $250,000.

The monthly ceiling as prescribed by §303.005[3] for the period of January 1, 2007 - January 31, 2007 is 18% for Consumer/Agricultural/Commercial/credit thru $250,000.

The monthly ceiling as prescribed by §303.005 for the period of January 1, 2007 - January 31, 2007 is 18% for Commercial over $250,000.

[1] Credit for personal, family or household use.

[2] Credit for business, commercial, investment or other similar purpose.

[3] For variable rate commercial transactions only.

TRD-200606898
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: December 27, 2006

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Texas Education Agency

Request for Applications Concerning Texas High Schools that Work Enhanced Design Network Grants, Cycle 2

Eligible Applicants. The Texas Education Agency (TEA) is requesting applications under Request for Applications (RFA) #701-07-105 from eligible school districts or open-enrollment charter schools. A school district or open-enrollment charter school may apply on behalf of an eligible campus, which includes: (1) a campus serving students in Grades 9 - 12 (A campus serving Grade 9 or Grades 9 - 10 may combine with a senior high school campus to submit one application on behalf of both campuses.); (2) a campus that is not a Disciplinary Alternative Education Program campus or a Juvenile Justice Alternative Education Program campus; (3) a campus that is not a recipient of: (a) a Texas High School Redesign and Restructuring Grant, Cycle 1, Cycle 2, or Cycle 3; (b) a Comprehensive School Reform (CSR)--Texas High School Initiative grant; (c) an Early College High School grant; (d) a Middle College/Early College High School Expansion grant; (e) a Texas Science, Technology, Engineering, and Math (T-STEM) Academy Startup or Implementation grant; or (f) a Redesign, Early College High School, or T-STEM grant from the Communities Foundation of Texas or the Bill and Melinda Gates Foundation; (4) a campus that is not a recipient of a 2006-2008 Texas High Schools That Work Enhanced Design Network Program grant (SAS-A432-06); and (5) a campus either: (a) within a district with a Stage 3 or Stage 4 intervention level for Career and Technology Education under the 2006-2007 TEA Performance-Based Monitoring System; (b) with a final rating of *Academically Unacceptable* in 2006 under the state accountability rating system; or (c) that participated as an official member of the High Schools That Work (HSTW) statewide network during the 2005-2006 school year.

A school district or open-enrollment charter school applying for this grant must be financially viable as determined through fiscal review by the TEA Division of Financial Audits. Additionally, to maintain eligibility for this grant, both the school district or open-enrollment charter school and the campus under the school district or open-enrollment charter school must be in compliance with all intervention requirements as established by the TEA Division of Program Monitoring and Interventions. An open-enrollment charter high school campus shall become ineligible for grant funding (or if a campus has applied for and received funding for this grant, will have its grant funding placed on hold) if the commissioner of education notifies the campus' charter holder of the commissioner's intent to revoke or non-renew such charter under Texas Education Code (TEC), Chapter 12, or to close the campus under TEC, Chapter 39, for any of the reasons set forth in either statutory provision. If the commissioner of education ultimately revokes or denies renewal of an open-enrollment charter or closes a campus that has been awarded funds under this grant program, grant funding shall be discontinued.

Description. The purpose of the Texas High Schools That Work Enhanced Design Network Grants, Cycle 2, is to support under-performing high schools in the use of the HSTW school improvement design as a framework to improve academic and career/technology instruction and overall student achievement. The primary goal of this grant program is for high schools to implement the following HSTW key design principles: (1) a challenging curriculum for all high school students, including four credits of mathematics, four credits in a career/technology concentration, and four credits in an academic concentration, with at least one of those credits being Advanced Placement (AP), International Baccalaureate (IB), or dual credit; (2) schoolwide literacy goals across the curriculum; (3) intervention strategies for equipping under-prepared students for challenging high school work; (4) programs to reduce the failure rate at ninth grade; and (5) links to postsecondary. Applicants will be required to demonstrate how school district resources, including in-kind resources, will be dedicated toward the project; how the campus will use the HSTW school improvement consultants and incorporate identified professional development into their campus improvement plans; and how the program will be sustained using other funding sources, including federal, state, local, or private funds, beyond the life of the project period.

Dates of Project. The Texas High Schools That Work Enhanced Design Network Grants, Cycle 2, will be implemented during the 2007-2008 and 2008-2009 school years. Applicants should plan for a starting date of no earlier than May 1, 2007, and an ending date of no later than May 31, 2009.

Project Amount. A total of approximately $900,000 is available for funding Texas High Schools That Work Enhanced Design Network Grants, Cycle 2. Each high school campus will receive a maximum of $60,000 to implement HSTW key design principles. This project is funded 100 percent from general revenue funds appropriated by Rider 59, General Appropriations Act, 2005.

Selection Criteria. Applications will be selected based on expert reviewers' assessment of each applicant's ability to carry out all requirements contained in the RFA. Reviewers will evaluate applications based on the overall quality and validity of the proposed grant programs and the extent to which the applications address the primary objectives and intent of the project. Applications must address each requirement as specified in the RFA to be considered for funding. The TEA reserves the right to select from the highest-ranking applications those that address all requirements in the RFA, contain a comprehensive plan that will fundamentally change and improve the high school campus, and demonstrate an ability to sustain the changes after the grant period ends.

Technical Assistance. Through the Region 5 Education Service Center (ESC), the TEA will provide pre-grant support and guidance in the development of plans that address both campus needs and grant requirements. Through the Region 5 ESC, the TEA will also provide direct training, on-going regional training, and networking activities to those high school campuses that receive the Texas High Schools That Work Enhanced Design Network Grants, Cycle 2.

The TEA is not obligated to approve an application, provide funds, or endorse any application submitted in response to this RFA. This RFA does not commit TEA to pay any costs before an application is approved. The issuance of this RFA does not obligate TEA to award a grant or pay any costs incurred in preparing a response.

Requesting the Application. A complete copy of RFA #701-07-105 may be obtained by writing the Document Control Center, Room 6-108, Texas Education Agency, William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701; by calling (512) 463-9304; by faxing (512) 463-9811; or by e-mailing dcc@tea.state.tx.us. Please refer to the RFA number and title in your request. Provide your name, complete mailing address, and phone number including area code. The announcement letter and complete RFA will also be posted on the TEA website at http://www.tea.state.tx.us/opge/disc/index.html for viewing and downloading.

Further Information. For clarifying information about the RFA, contact Karen Harmon, Division of Discretionary Grants, TEA, (512) 463-9269. In order to assure that no prospective applicant may obtain a competitive advantage because of acquisition of information unknown to other prospective applicants, any information that is different from or in addition to information provided in the RFA will be provided only in response to written inquiries. Copies of all such inquiries and the written answers thereto will be posted on the TEA website in the format of Frequently Asked Questions (FAQs) at http://www.tea.state.tx.us/opge/disc/index.html.

Deadline for Receipt of Applications. Applications must be received in the Document Control Center of the TEA by 5:00 p.m. (Central Time), Thursday, March 1, 2007, to be considered for funding.

TRD-200700011
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: January 3, 2007

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Request for Applications Concerning the State Engineering and Science Recruitment (SENSR) Fund, 2007-2008

Eligible Applicants. The Texas Education Agency (TEA) is requesting applications under Request for Applications (RFA) #701-07-104 from organizations that qualify for exemption from federal income tax under the Internal Revenue Code, 501(c)(3), and that do not distribute net earnings to any private shareholder or other individual. The organization must serve groups of women or minority group members who, considering their percentages of the Texas population, are underrepresented at institutions of higher education in programs of engineering and applied sciences.

Description. The purpose of this program is to allocate funds to eligible organizations to establish or operate educational programs. The programs will support the recruitment of women and members of ethnic minority groups to assist them in preparing for, or participating in, programs leading to an undergraduate degree in engineering or applied science from an institution of higher education. Funding shall also be used to disseminate information concerning career opportunities in engineering and science, as well as information about these programs that are funded under Texas Education Code, §§51.601 - 51.608, and Senate Bill 1, General Appropriations Act, Article III, Rider 18, 79th Texas Legislature, 2005.

Dates of Project. The State Engineering and Science Recruitment (SENSR) grant will be implemented during the 2007-2008 school year. Applicants should plan for a starting date of no earlier than June 1, 2007, and an ending date of no later than May 31, 2008.

Project Amount. Funding will be provided for approximately 16 projects. Each project will receive a maximum of $25,000 for the 2007-2008 school year. For the first year, this project will distribute a total amount of approximately $394,920 subject to the availability of funds and approval of the commissioner of education. Project funding in the second year will be based on satisfactory progress of the first-year objectives and activities and on budget approval by the commissioner of education.

Selection Criteria. Applications will be selected based on the independent reviewers' assessment of each applicant's ability to carry out all requirements contained in the RFA. Reviewers will evaluate applications based on the overall quality and validity of the proposed grant program and the extent to which the application addresses the primary objective(s) and intent of the project. Applications must address each requirement as specified in the RFA to be considered for funding. Preference shall be given to projects that emphasize the development of mathematical and scientific competence. Projects in the social sciences will not be considered. The TEA reserves the right to select from the highest ranking applications those that would serve the most participants who are women and underrepresented minority group members in the objectives specified. Other project quality indicators are specified throughout the RFA. To be approved for funding, projects offered by eligible organizations must meet the following guidelines: (1) use professional volunteers at each level of instruction; (2) require parental involvement; (3) coordinate with public schools' preparation for scientific and mathematics careers; (4) coordinate with post-secondary educational institutions; (5) involve organizations of women and minority group members; (6) provide demonstrated professional leadership in educational activities for women and minority group members; and (7) be compatible with state and federal laws governing education.

The TEA is not obligated to approve an application, provide funds, or endorse any application submitted in response to this RFA. This RFA does not commit TEA to pay any costs before an application is approved. The issuance of this RFA does not obligate TEA to award a grant or pay any costs incurred in preparing a response.

Requesting the Application. A complete copy of RFA #701-07-104 may be obtained by writing the Document Control Center, Room 6-108, Texas Education Agency, William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701; by calling (512) 463-9304; by faxing (512) 463-9811; or by e-mailing dcc@tea.state.tx.us. Please refer to the RFA number and title in your request. Provide your name, complete mailing address, and phone number including area code. The announcement letter and complete RFA will also be posted on the TEA website at http://www.tea.state.tx.us/opge/disc/index.html for viewing and downloading.

Further Information. For clarifying information about the RFA, contact Kathy Mihalik, Division of Discretionary Grants, Texas Education Agency, (512) 463-7322. In order to assure that no prospective applicant may obtain a competitive advantage because of acquisition of information unknown to other prospective applicants, any information that is different from or in addition to information provided in the RFA will be provided only in response to written inquiries. Copies of all such inquiries and the written answers thereto will be posted on the TEA website in the format of Frequently Asked Questions (FAQs) at http://www.tea.state.tx.us/opge/disc/index.html.

Deadline for Receipt of Applications. Applications must be received in the Document Control Center of the Texas Education Agency by 5:00 p.m. (Central Time), Tuesday, February 27, 2007, to be eligible to be considered for funding.

TRD-200700012
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: January 3, 2007

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Texas Commission on Environmental Quality

Notices of District Petition

Notices issued December 20 and December 21, 2006

TCEQ Internal Control No. 05152006-D02; Texas National Municipal Utility District of Montgomery County has applied to the Texas Commission on Environmental Quality (TCEQ) for authority to adopt and impose an annual uniform operations and maintenance standby fee up to $84 per equivalent single family connection per year for calendar years 2007-2009, on unimproved property within the District. Also, the District will allow a maintenance tax rate not exceeding $.75 per $100 taxable valuation. The application was filed pursuant to Chapter 49 of the Texas Water Code, 30 Texas Administrative Code Chapter 293, and under the procedural rules of the TCEQ. The TCEQ may approve the annual standby fees as requested, or it may approve a lower annual standby fee, but it shall not approve an annual standby fee greater than the amount requested. The standby fee is a personal obligation of the person owning the undeveloped property on January 1 of the year for which the fee is assessed. A person is not relieved of his pro-rated share of the standby fee obligation on transfer of title to the property. On January 1 of each year, a lien is attached to the undeveloped property to secure payment of any standby fee imposed and the interest or penalty, if any, on the fee. The lien has the same priority as a lien for taxes of the District. The purpose of standby fees is to distribute a fair portion of the cost burden for operations and maintenance costs and debt service of the District facilities to owners of property who have not constructed vertical improvements but have water, wastewater or drainage facilities or services available. Any revenues collected from the operations and maintenance standby fees shall be used to supplement the District's operations and maintenance account.

TCEQ Internal Control No. 06212006-D01; Northeast Uvalde Partners, Ltd., Land Development Company, Ltd., and Sowell Equities-Forestwood, L.P. (Petitioner) filed a petition for the creation of Harris County Municipal Utility District No. 421 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states the following: (1) the Petitioner is the holder of title to a majority in value of the land to be included in the proposed District; (2) RFC Construction Funding Corporation is the only lien holder on the property to be included in the proposed District, and has signed the petition evidencing its consent to the creation of the proposed District; (3) the proposed District will contain approximately 229.978 acres located in Harris County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Houston, Texas, and no portion of land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any other city, town or village in Texas. By Ordinance No. 2004-1276, effective December 21, 2004, the City of Houston, Texas, gave its consent to the creation of the proposed District.

TCEQ Internal Control No. 12072006-D05; FRM/MRA Holdings #1, Ltd., (Petitioner) filed a petition for creation of Harris County Municipal Utility District No. 424 (District) with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition states the following: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) there are no lien holders on the property to be included in the proposed District, (3) the proposed District will contain approximately 316.45 acres located within Harris County, Texas; and (4) the proposed District is within the extraterritorial jurisdiction of the City of Houston, Texas, and no portion of land within the proposed District is within the corporate limits or extraterritorial jurisdiction of any other city, town or village in

Texas. By Ordinance No. 2006-339, effective April 18, 2006, the City of Houston, Texas, gave its consent to the creation of the proposed District.

INFORMATION SECTION

The TCEQ may grant a contested case hearing on this petition if a written hearing request is filed within 30 days after the newspaper publication of this notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Districts Review Team, at (512) 239-4691. Si desea información en Español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-200606900
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: December 27, 2006

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Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations, the proposed penalty, and the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission, in accordance with Texas Water Code (TWC), §7.075, this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **February 12, 2007**. The commission will consider any written comments received; and the commission may withdraw or withhold approval of a DO if a comment discloses facts or considerations that indicate that consent to the proposed DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed DO is not required to be published if those changes are made in response to written comments.

A copy of each proposed DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the DO should be sent to the attorney designated for the DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on February 12, 2007**. Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission's attorneys are available to discuss the DOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the DOs shall be submitted to the commission in **writing**.

(1) COMPANY: Alex, Inc. dba Brothers II Cleaners; DOCKET NUMBER: 2006-0908-DCL-E; TCEQ ID NUMBER: RN100687896; LOCATION: 3939 Boat Club Road, Lake Worth, Tarrant County, Texas; TYPE OF FACILITY: dry cleaning drop station; RULES VIOLATED: 30 TAC §337.11(e) and Texas Health and Safety Code (THSC), §374.102, by failing to renew the facility's registration by completing and submitting the required registration form to the TCEQ for a dry cleaning and/or drop station facility; PENALTY: $955; STAFF ATTORNEY: Mary Hammer, Litigation Division MC 175, (512) 239-2496; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(2) COMPANY: Ali Bukhari dba Honey Stop and Sue Bukhari dba Honey Stop; DOCKET NUMBER: 2004-1803-PST-E; TCEQ ID NUMBER: RN102716024; LOCATION: 401 East Avenue, Baytown, Harris County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum underground storage tanks (USTs); PENALTY: $1,090; STAFF ATTORNEY: Shannon Strong, Litigation Division, MC 175, (512) 239-0972; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(3) COMPANY: Dennis A. Holmes; DOCKET NUMBER: 2006-0265-WTR-E; TCEQ ID NUMBER: RN103372447; LOCATION: 4525 Brookside Drive, Vidor, Hardin County, Texas; TYPE OF FACILITY: public water supply; RULES VIOLATED: 30 TAC §30.381(b) and THSC, §341.034(a), by failing to operate the facility on a contract basis without an adequate license or registration issued by the commission; PENALTY: $313; STAFF ATTORNEY: Shawn Slack, Litigation Division, MC 175, (512) 239-0063; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1892, (409) 898-3838.

(4) COMPANY: First Gatesville Venture, Inc. dba Amigos 3; DOCKET NUMBER: 2005-1246-PST-E; TCEQ ID NUMBER: RN102357019; LOCATION: 3102 South Presa Street, San Antonio, Bexar County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to provide acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum USTs; and 30 TAC §334.22(a) and Texas Water Code (TWC), §5.702, by failing to pay UST fees for TCEQ Account No. 0062750U for Fiscal Year 2005; PENALTY: $3,150;

STAFF ATTORNEY: Xavier Guerra, Litigation Division, MC R-13, (210) 403-4016; REGIONAL OFFICE: San Antonio Regional Office, 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(5) COMPANY: Jim B. Clemons; DOCKET NUMBER: 2006-0470-OSI-E; TCEQ ID NUMBER: RN103390274; LOCATION: 302 North Scruggs, Corsicana, Navarro County, Texas; TYPE OF FACILITY: unlicensed on-site sewage facility; RULES VIOLATED: 30 TAC §285.61(1), TWC, §37.003, and THSC, §366.071(a), by failing to obtain a license prior to installing an on-site sewage facility; and 30 TAC §285.61(6) and THSC, §366.004, by failing to meet the minimum criteria for an on-site sewage facility; PENALTY: $1,125; STAFF ATTORNEY: Shawn Slack, Litigation Division, MC 175, (512) 239-0063; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(6) COMPANY: Kyo M. Chung dba VIP Cleaner; DOCKET NUMBER: 2006-0768-DCL-E; TCEQ ID NUMBER: RN104097753; LOCATION: 1729 Greenville Avenue, Dallas, Dallas County, Texas; TYPE OF FACILITY: dry cleaning facility; RULES VIOLATED: 30 TAC §337.11(e) and THSC, §374.102, by failing to renew the facility's registration by completing and submitting to the TCEQ the required registration form for a dry cleaning facility; and 30 TAC §337.14(c) and TWC, §5.702, by failing to pay dry cleaner registration fees and associated late fees for TCEQ Financial Administration Account No. 24002135 for Fiscal Year 2005; PENALTY: $1,185; STAFF ATTORNEY: Lena Roberts, Litigation Division, MC 175, (512) 239-0019; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(7) COMPANY: Marti M. Carder dba Pier 57; DOCKET NUMBER: 2005-1683-PWS-E; TCEQ ID NUMBER: RN104393004; LOCATION: 27446 Farm-to-Market Road 457, Sargent, Matagorda County, Texas; TYPE OF FACILITY: restaurant with a public water supply system; RULES VIOLATED: 30 TAC §290.109(c)(2)(A)(i) and §290.122(c)(2)(B) and THSC, §341.033(d), by failing to collect routine water samples for bacteriological analysis for the months of August and September 2004, and February 2005, and by failing to post public notification of those sampling violations; and TWC, §5.702, by failing to pay the Public Health Service fee for Fiscal Year 2004 for TCEQ Financial Administration Account No. 91610042; PENALTY: $1,118; STAFF ATTORNEY: Lena Roberts, Litigation Division, MC 175, (512) 239-0019; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(8) COMPANY: North Bengal, Inc. dba Dry Clean Super Center; DOCKET NUMBER: 2006-0870-DCL-E; TCEQ ID NUMBER: RN104091012; LOCATION: 1301 North Main Street, Euless, Tarrant County, Texas; TYPE OF FACILITY: dry cleaning facility; RULES VIOLATED: 30 TAC §337.11(e) and THSC, §374.102, by failing to renew the facility's registration by completing and submitting the required registration form to the TCEQ for a dry cleaning and/or drop station facility; PENALTY: $1,185; STAFF ATTORNEY: Mary Hammer, Litigation Division MC 175, (512) 239-2496; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(9) COMPANY: OK Concrete Company; DOCKET NUMBER: 2005-1140-AIR-E; TCEQ ID NUMBER: RN101302479; LOCATION: 319 South Avenue C, Olney, Young County, Texas; TYPE OF FACILITY: concrete batch plant; RULES VIOLATED: THSC, §382.0518(a) and §382.085(b), by failing to obtain authorization to operate a concrete batch plant; PENALTY: $1,340,000; STAFF ATTORNEY: Shannon Strong, Litigation Division, MC 175, (512) 239-0972; REGIONAL OFFICE: Abilene Regional Office, 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(10) COMPANY: Robert (Bobby) Barton McCans, Jr. dba Aaron Irrigation and Landscaping Co.; DOCKET NUMBER: 2002-0695-LII-E; TCEQ ID NUMBERS: RN103457198; LOCATION: 1417 Broke Spoke Court, Fort Worth, Tarrant County, Texas; TYPE OF FACILITY: landscape irrigation systems; RULES VIOLATED: 30 TAC §§30.5(a) and (b), 30.125, and 344.4(a); Texas Occupational Code, §1903.251; and TWC, §37.003 and §37.006, by installing landscape irrigation systems without a valid license; PENALTY: $3,125; STAFF ATTORNEY: Alfred Oloko, Litigation Division, MC R-12, (713) 422-8918; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

TRD-200700005
Mary Risner
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 3, 2007

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Notice of Opportunity to Comment on Settlement Agreements of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. Section 7.075 requires that, before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **February 12, 2007**. Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on February 12, 2007**. Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, §7.075 provides that comments on an AO shall be submitted to the commission in **writing**.

(1) COMPANY: Chilton Water Supply and Sewer Service Corporation; DOCKET NUMBER: 2005-0887-MWD-E; TCEQ ID NUMBER: RN102285814; LOCATION: approximately 0.7 miles east of State Highway 77 and one mile south of the City of Chilton, Falls County, Texas; TYPE OF FACILITY: wastewater treatment plant; RULES VIOLATED: 30 TAC §305.125(1); Texas Water Code (TWC), §26.121(a)(1); and Texas Pollutant Discharge Elimination System (TPDES) Permit No. 10811-001, Effluent Limitations and Monitoring Requirements Nos. 1, 2, and 4, Operational Requirements No. 1 and Permit Conditions No. 2.g., by failing to prevent the discharge and accumulation of solids in the receiving stream and

unauthorized discharges which occurred around the influent bar screen and aeration basin; 30 TAC §305.125(1) and (5) and TPDES Permit No. 10811-001, Operational Requirements No. 1, by failing to ensure that all systems of collection, treatment, and disposal were properly operated and maintained; 30 TAC §§305.125(1), 319.4, 319.7(a) and (c), and 319.11(b) and TPDES Permit No. 10811-001, Monitoring and Reporting Requirements Nos. 2, 3.b. and 3.c., by failing to have records available for review by a TCEQ representative during the investigation; 30 TAC §305.125(1) and (9) and TPDES Permit No. 10811-001, Monitoring and Reporting Requirements Nos. 7.a. and 7.c., Section III. Requirements Applying to All Sewage Sludge Disposed in a Municipal Solid Waste Landfill, and Paragraph G., by failing to report exceedances which deviated from the permitted limit by greater than 40%, failing to report an unauthorized discharge, and failing to submit an annual sludge report; and 30 TAC §317.4(a)(8), by failing to conduct the required annual testing of the drinking water backflow prevention device; PENALTY: $22,750; STAFF ATTORNEY: Mark Curnutt, Litigation Division, MC 175, (512) 239-0624; REGIONAL OFFICE: Waco Regional Office, 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(2) COMPANY: Eutemia Medina dba O.A. Gingrich; DOCKET NUMBER: 2002-0488-PST-E; TCEQ ID NUMBER: 46358; LOCATION: 121 North Vineyard, Sinton, San Patricio County, Texas; TYPE OF FACILITY: convenience store with four underground storage tanks, that formerly dispensed gasoline for retail sales; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate the required financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases from the petroleum underground storage tanks (USTs); 30 TAC §334.50(b)(1)(A) and (2)(A) and TWC, §26.3475, by failing to monitor USTs for releases at a frequency of at least once per month (not to exceed 35 days between monitoring), and by failing to monitor the piping connected to the UST system in a manner designed to detect releases from any portion of the UST piping system; 30 TAC §334.7(d)(3), by failing to amend, update, or change the UST registration information in order to reflect current operational status within 30 days of the date on which the owner and/or operator became aware of the change; 30 TAC §334.49(a) and TWC, §26.3475, by failing to provide corrosion protection for the UST system; and 30 TAC §334.22(a), by failing to pay the required outstanding annual UST facility fees for Fiscal Years 1994-2001 (UST facility Account No. 0050099U); PENALTY: $7,000; STAFF ATTORNEY: Shawn Slack, Litigation Division, MC 175, (512) 239-0063; REGIONAL OFFICE: Corpus Christi Regional Office, 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(3) COMPANY: General Dynamics OTS (Garland), L.P.; DOCKET NUMBER: 2005-1672-AIR-E; TCEQ ID NUMBER: RN102660909; LOCATION: 1200 North Glenbrook Drive, Garland, Dallas County, Texas; TYPE OF FACILITY: ordnance production facility; RULES VIOLATED: 30 TAC §116.115(b)(2)(F); Texas Health and Safety Code (THSC), §382.085(b); and New Source Review (NSR) Permit No. 51412, General Condition No. 8, by failing to comply with permitted Maximum Allowable Emission Rates for the plaforization system at emission point number 7-PLAF-PRETREAT for volatile organic compounds; 30 TAC §116.115(b)(2)(E) and (c); THSC, §382.085(b); NSR Permit No. 51412, General Condition No. 7 and Special Condition Nos. 11B, C, and D, by failing to maintain records and data to demonstrate compliance with the permit in a readily available form for TCEQ; 30 TAC §106.433(8)(B), (8)(C), and (8)(D) and THSC, §382.085(b), by failing to maintain and make permit by rule (PBR) records for a surface coating facility immediately available to TCEQ staff; and 30 TAC §106.8(c); THSC, §382.085(b), by failing to maintain records containing sufficient information to demonstrate compliance with PBR requirements; PENALTY: $86,775; STAFF ATTORNEY: Kathleen Decker, Litigation Division, MC 175, (512) 239-6500; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(4) COMPANY: South Texas Chlorine, Inc.; DOCKET NUMBER: 2004-0142-MLM-E; TCEQ ID NUMBER: RN100843044; LOCATION: 8600 East Harrison, Harlingen, Cameron County, Texas; TYPE OF FACILITY: chemical repackaging plant; RULES VIOLATED: 30 TAC §116.115(c), THSC, §382.085(b), and NSR Permit No. 21286, Special Condition No. 8, by failing to properly monitor the concentration of the scrubbing solution at least once per shift as required by the permit; 30 TAC §116.115(c), THSC, §382.085(b), and NSR Permit No. 21286, Special Condition No. 25, by failing to maintain the maximum allowed bleach production limit of 120 batches per year; 30 TAC §116.115(c), THSC, §382.085(b), and NSR Permit No. 21286, Special Condition Nos. 26(A), (D), and (F) - (H), by failing to meet the record keeping requirements; 30 TAC §281.25(a)(4) and §335.4; Multi Sector General Permit (MSGP) No. TXR05H669, Part III, Section A(3)(a) and (b); and TWC, §26.121, by failing to identify and obtain a permit for non-storm water discharge; 30 TAC §281.25(a)(4) and MSGP No. TXR05H669, Part III, Sections A(4)(a), (b), and (c), by failing to include items in the Storm Water Pollution Prevention Plan (SWP3); 30 TAC §281.25(a)(4) and MSGP No. TXR05H669, Part III, Section A(5)(b), (f), and (h), by failing to include a detailed description in the SWP3; and 30 TAC §335.62 and 40 Code of Federal Regulations (CFR) §262.11, by failing to complete a hazardous waste determination of the two water waste streams generated as a result of the washing of compressed gas cylinders and the one-ton containers in the scrubber tanks; PENALTY: $5,100; STAFF ATTORNEY: Laurencia Fasoyiro, Litigation Division, MC R-12, (713) 422-8914; REGIONAL OFFICE: Harlingen Regional Office, 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(5) COMPANY: Teer Plating Co., Inc.; DOCKET NUMBER: 2004-2109-IHW-E; TCEQ ID NUMBER: RN100585520; LOCATION: 6111 Wyche Boulevard, Dallas, Dallas County, Texas; TYPE OF FACILITY: electroplating and metal finishing facility; RULES VIOLATED: 30 TAC §335.69(f)(4)(A), and (a)(2) and (3) and 40 CFR §262.34(d)(4), by failing to keep hazardous waste closed during storage; and 30 TAC §335.4 and TWC, §26.121, by failing to prevent the unauthorized discharge of waste or pollutants into or adjacent to waters in the state; PENALTY: $35,000; STAFF ATTORNEY: James Sallans, Litigation Division, MC 175, (512) 239-2053; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(6) COMPANY: Uppal Bros., Inc. dba Save Way Food Mart; DOCKET NUMBER: 2003-1165-PST-E; TCEQ ID NUMBER: RN102035367; LOCATION: 6620 Brentwood Stair Road, Fort Worth, Tarrant County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.49(a) and TWC, §26.3475(d), by failing to install a method of corrosion protection for the UST systems; 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum USTs; 30 TAC §334.50(b)(1)(A) and (d)(1)(B)(ii) and TWC, §26.3475(c)(1), by failing to monitor USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); 30 TAC §334.48(c), by failing to conduct effective manual or automatic inventory control procedures for the UST systems; 30 TAC §334.8(c)(5)(C), by failing to ensure that a legible tag, label, or marking with the tank number was permanently applied upon or affixed to either the top of the fill tube or to a nonremovable point in the immediate area of the fill

tube according to the UST registration and self-certification form; 30 TAC §334.8(c)(4)(A)(vii) and (c)(5)(B)(ii) and TWC, §26.346(c)(3), by failing to timely renew the delivery certificate by submitting a properly completed UST registration and self-certification form at least 30 days before the expiration date of the delivery certificate; and 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the petroleum USTs; PENALTY: $35,100; STAFF ATTORNEY: Shawn Slack, Litigation Division, MC 175, (512) 239-0063; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

TRD-200700004
Mary Risner
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 3, 2007

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Texas Higher Education Coordinating Board

Request for Proposals for Comprehensive Classification and Compensation Study

This RFP Notice Includes Revisions to the Due Date Listed in the Original Posting in the December 29, 2006, Issue of the *Texas Register* (31 TexReg 10958).

Texas Higher Education Coordinating Board is soliciting proposals from interested, highly qualified, and experienced consulting firms to design, conduct, and assist in the implementation of a comprehensive classification and compensation study of the agency's positions staffed by full-time and part-time employees. A Request for Proposals (RFP), which includes instructions for its completion, is available on the Electronic State Business Daily (ESBD) at: http://esbd.tbpc.state.tx.us/bid_show.cfm?bidid=68527

Respondents to this RFP shall submit completed proposals in a sealed envelope, clearly marked with "Proposal for THECB Classification and Compensation Study" and the name of the bidder.

Seven (7) copies of the proposal must be submitted by 12:00 p.m., Central Standard Time, on January 22, 2007 to the following address:

Texas Higher Education Coordinating Board

ATTN: Anthony O. Tegbe

1200 East Anderson Lane, Room 2.177

Austin, TX 78752

If you have any questions about the RFP, please submit your inquiries in writing, preferably via e-mail to:

Betty Sharp

Director of Personnel

Texas Higher Education Coordinating Board

1200 East Anderson Lane

Austin, TX 78752

Email: betty.sharp@thecb.state.tx.us

TRD-200700003
Bill Franz
General Counsel
Texas Higher Education Coordinating Board
Filed: January 3, 2007

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Texas Department of Insurance

Company Licensing

Application for incorporation to the State of Texas by WELLCARE OF TEXAS, INC., a domestic health maintenance organization (HMO). The home office is in Austin, Texas.

Application to change the name of HOMEWISE PREFERRED INSURANCE COMPANY to ATLANTIC & GULF STATES INSURANCE COMPANY, a foreign fire and/or casualty company. The home office is in Tampa, Florida.

Application to change the name of NORTH AMERICA LIFE INSURANCE COMPANY OF TEXAS to NORTH AMERICA LIFE INSURANCE COMPANY, a domestic life, accident and/or health company. The home office is in Austin, Texas.

Application to change the name of ACE AMERICAN REINSURANCE COMPANY to R&O REINSURANCE COMPANY, a foreign fire and/or casualty company. The home office is in Philadelphia, Pennsylvania.

Any objections must be filed with the Texas Department of Insurance, within twenty (20) calendar days from the date of the *Texas Register* publication, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, M/C 305-2C, Austin, Texas 78701.

TRD-200700008
Gene C. Jarmon
Chief Clerk and General Counsel
Texas Department of Insurance
Filed: January 3, 2007

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Third Party Administrator Applications

The following third party administrator application has been filed with the Texas Department of Insurance and is under consideration.

Application of NORTHWEST DIAGNOSTIC CLINIC IPA, LLC, a domestic third party administrator. The home office is HOUSTON, TEXAS.

Any objections must be filed within 20 days after this notice is published in the *Texas Register*, addressed to the attention of Matt Ray, MC 107-1A, 333 Guadalupe, Austin, Texas 78701.

TRD-200606901
Gene C. Jarmon
Chief Clerk and General Counsel
Texas Department of Insurance
Filed: December 27, 2006

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Texas Lottery Commission

Instant Game Number 801 "Break the Bank"

1.0 Name and Style of Game.

A. The name of Instant Game No. 801 is "BREAK THE BANK". The play style is "key number match with auto win".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 801 shall be $2.00 per ticket.

1.2 Definitions in Instant Game No. 801.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, $1.00, $2.00, $4.00, $6.00, $10.00, $20.00, $50.00, $200, $1,000, $3,000, $30,000, and MONEYSTACK SYMBOL.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 801 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$6.00	SIX$
$10.00	TEN$
$20.00	TWENTY
$50.00	FIFTY
$200	TWO HUND
$1,000	ONE THOU
$3,000	THR THOU
$30,000	30 THOU
MONEYSTACK SYMBOL	WIN$

E. Retailer Validation Code - Three (3) letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. These three (3) small letters are for validation purposes and cannot be used to play the game. The possible validation codes are:

Figure 2: GAME NO. 801 - 1.2E

CODE	PRIZE
TWO	$2.00
FOR	$4.00
SIX	$6.00
EGT	$8.00
TEN	$10.00
TWL	$12.00
TWN	$20.00

Low-tier winning tickets use the required codes listed in Figure 2. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 (thirteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 0000000000000.

G. Low-Tier Prize - A prize of $2.00, $4.00, $6.00, $8.00, $10.00, $12.00 or $20.00.

H. Mid-Tier Prize - A prize of $50.00 or $200.

I. High-Tier Prize - A prize of $1,000, $3,000 or $30,000.

J. Bar Code - A 22 (twenty-two) character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A 13 (thirteen) digit number consisting of the three (3) digit game number (801), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001and end with 250 within each pack. The format will be: 801 -0000001-001.

L. Pack - A pack of "BREAK THE BANK" Instant Game tickets contains 250 tickets, packed in plastic shrink-wrapping and fanfolded in pages of two (2). Tickets 001 and 002 will be on the top page; tickets 003 and 004 on the next page; etc.; and tickets 249 and 250 will be on the last page. Please note the books will be in an A - B configuration.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "BREAK THE BANK" Instant Game No. 801 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "BREAK THE BANK" Instant Game is determined once the latex on the ticket is scratched off to expose 19 (nineteen) play symbols. If the player matches any of YOUR NUMBERS play symbols to any of the 3 LUCKY NUMBERS play symbols, the player wins the prize shown for that number. If the player reveals a "moneystack" symbol, the player wins the prize instantly. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 19 (nineteen) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 19 (nineteen) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 19 (nineteen) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 19 (nineteen) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets will not have identical play data, spot for spot.

B. Non-winning prize symbols will not match a winning prize symbol on a ticket.

C. No duplicate Lucky Numbers on a ticket.

D. There will be no correlation between the matching symbols and the prize amount.

E. The auto win symbol will never appear more than once on a ticket.

F. No duplicate non-winning play symbols on a ticket.

2.3 Procedure for Claiming Prizes.

A. To claim a "BREAK THE BANK" Instant Game prize of $2.00, $4.00, $6.00, $8.00, $10.00, $12.00, $20.00, $50.00 or $200, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not in some cases, required to pay a $50.00 or $200 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and 2.3.C of these Game Procedures.

B. To claim a "BREAK THE BANK" Instant Game prize of $1,000, $3,000 or $30,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "BREAK THE BANK" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Health and Human Services Commission for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resource Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "BREAK THE BANK" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "BREAK THE BANK" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code Section 466.408. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 25,200,000 tickets in the Instant Game No. 801. The approximate number and value of prizes in the game are as follows:

Figure 3: GAME NO. 801 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$2	2,318,400	10.87
$4	1,486,800	16.95
$6	428,400	58.82
$8	100,800	250.00
$10	226,800	111.11
$12	252,000	100.00
$20	176,400	142.86
$50	93,450	269.66
$200	20,790	1,212.12
$1,000	525	48,000.00
$3,000	77	327,272.73
$30,000	12	2,100,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.94. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 801 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 801, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200606902

Kimberly Kiplin
General Counsel
Texas Lottery Commission
Filed: December 27, 2006

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Public Utility Commission of Texas

Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on December 22, 2006, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Time Warner Cable for an Amendment to a State-Issued Certificate of Franchise Authority, Project Number 33677 before the Public Utility Commission of Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All inquiries should reference Project Number 33677.

TRD-200606904
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 28, 2006

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Notice of Application for Waiver from Requirements

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on December 21, 2006, for waiver from the requirements in P.U.C. Substantive Rules §26.54(b)(3) and (4)(C).

Docket Title and Number: Application of Big Bend Telephone Company, Incorporated for a Temporary Extension of Waiver from Requirements in P.U.C. Substantive Rules §26.54(b)(3) and (4)(C); Docket Number 33676.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 33676.

TRD-200606903
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 28, 2006

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Notice of Application to Amend a Certificate of Convenience and Necessity for a Proposed Transmission Line in Randall County, Texas

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) an application on December 20, 2006, to amend a certificate of convenience and necessity for a proposed transmission line in Randall County, Texas.

Docket Style and Number: Application of Southwestern Public Service Company to Amend a Certificate of Convenience and Necessity (CCN) for a Proposed Transmission Line in Randall County, Texas. Docket Number 33602.

The Application: The application of Southwestern Public Service Company (SPS) for a proposed transmission line is designated as the Amarillo South Interchange to Spring Draw Substation 115-kV Transmission Line Project. These facilities include approximately 5.41 miles of new 115 kV transmission line.

Persons wishing to intervene or comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. The deadline for intervention in this proceeding is February 5, 2007. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 33602.

TRD-200700009
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 3, 2007

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Notice of Petition for Expanded Local Calling Service

Notice is given to the public of the filing with the Public Utility Commission of Texas of a petition on November 22, 2006, for expanded local calling service (ELCS), pursuant to Chapter 55, Subchapter C of the Public Utility Regulatory Act (PURA). A summary of the application follows.

Project Title and Number: Petition for Expanded Local Calling Service from the Mirando City Exchange to the Exchanges of Bruni, Hebbronville and Laredo, Project Number 33530.

The petitioners in the Mirando City exchange request ELCS to the exchanges of Bruni, Hebbronville, and Laredo.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than January 26, 2007. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2789. All comments should reference Project Number 33530.

TRD-200700007
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 3, 2007

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Office of the Secretary of State

Correction of Error

The Office of the Secretary of State adopted new 1 TAC §81.60, concerning Voting System Certification Procedures. The adoption notice appeared in the January 5, 2007, issue of the *Texas Register* (32 TexReg 41).

Due to an error in Figure 1: 1 TAC §81.60(1), a sentence on page 107 reads: "Acknowledge which ITA has been notified to send 4 copies of the software and source code and expected delivery date to our office." As corrected, this sentence should read as follows:

"Acknowledge which voting system test laboratory has been notified to send a copy of the software and source code and expected delivery date to our office."

Due to an error in §81.60(2) on page 41, the rule text reads that the applicant must deliver four copies. In fact only one copy is required. As corrected, the paragraph should read as follows.

"(2) The applicant must have the nationally accredited voting system test laboratory deliver a copy of all nationally qualified software/firmware and source codes for the system and/or system

components requested for Texas certification, directly to the Secretary of State no later than 45 days prior to examination."

TRD-200700010

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Texas Department of Transportation

Aviation Division - Request for Proposals

The Airport Sponsors, through their agent the Texas Department of Transportation (TxDOT), intend to engage aviation professional engineering firms for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive proposals for professional aviation engineering design services described below:

Airport Sponsor: City of Corsicana, C. David Campbell Field-Corsicana Municipal Airport. TxDOT CSJ No.:0718CORSI. Scope: Provide engineering/design services to design and construct fueling pad; install supplemental windcone; repair hangar access taxiway; and install cyclone fencing at the David C. Campbell Field Airport, Corsicana, Texas. The DBE goal is set at 5%. TxDOT Project Manager is Charles Graham. Grant Manager is Edie Stimach. Six completed, unfolded copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 E. Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **February 6, 2007**, 4:00 p.m. Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Edie Stimach. The consultant selection committee will be composed of local government members.

Airport Sponsor: Aransas County, Aransas County Airport. TxDOT CSJ No. 0716RCKPT. Scope: Provide engineering/design services to Reconstruct Taxiway "A" from Taxiway "B" to Runway 18 end; Reconstruct Taxiway "D"; Rehabilitate Taxiway "E"; Overlay Taxiway "B"; Overlay Taxiway "A" from Taxiway "C" to Runway 14 end; Overlay Taxiway "C"; Construct Partial Taxiway to Runway 14-32; Install/Replace Signage and Install Erosion/Sedimentation Controls. The DBE goal is set at 11%. TxDOT Project Manager is John Wepryk, P.E. Grant Manager is Sheri Quinlan. Seven completed, unfolded copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 E. Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **February 6, 2007**, 4:00 p.m. Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Sheri Quinlan. The consultant selection committee will be composed of local government members.

Interested firms shall utilize the latest version of Form AVN-550, titled "Aviation Engineering Services Proposal". The form may be requested from TxDOT Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site, URL address **http://www.dot.state.tx.us/forms/aviation/550.doc**. The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. Proposals shall be stapled but not bound in any other fashion. PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT website as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is an MS Word Template.

For more information on these Request for Proposals go to the Aviation Consultant Contracts web page at **http://www.dot.state.tx.us/business/avnconsultinfo.htm** or contact the project specific Grant Manager for any procedural questions and the Project Manager for technical questions at 1-800-68-PILOT (74568).

TRD-200606895
Bob Jackson
General Counsel
Texas Department of Transportation
Filed: December 22, 2006

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Request for Proposals - Highway Safety Performance Plan

In accordance with 43 TAC §25.901, et seq., the Texas Department of Transportation (TxDOT) is requesting project proposals to support the goals and strategies of a traffic safety program to reduce the number of motor vehicle related crashes, injuries and fatalities in Texas. These goals and strategies form the basis for the Fiscal Year 2008 (FY08) Highway Safety Performance Plan (HSPP).

The authority and responsibility of the traffic safety grant program derives from the National Highway Safety Act of 1966 (23 USC §401, et seq.), and the Texas Traffic Safety Act of 1967 (Transportation Code, Chapter 723). Traffic Safety is an integral part of the Texas Department of Transportation and works through the department's 25 districts for local projects. The program is administered at the state level by the department's Traffic Operations Division. The executive director of the department is the designated Governor's Highway Safety Representative.

The following are the 2008 HSPP Program Areas for which projects may be submitted: Planning and Administration; Alcohol and Other Drug Countermeasures; Emergency Medical Services; Motorcycle Safety; Occupant Protection; Pedestrian/Bicycle Safety; Police Traffic Services; Speed Control; Traffic Records; Driver Education and Behavior; Railroad/Highway Crossing; Roadway Safety; Safe Communities; and School Bus. Eligible organizations are state and local governments, educational institutions, and non-profit organizations.

The Request for Proposals for Fiscal Year 2008, as well as the on-line eGrants proposal application system, is available on the TxDOT website at the following location: **http://www.dot.state.tx.us/services/traffic_operations/traffic_safety.htm**.

Proposals for FY08 must be completed using the eGrants system.

The new eGrants system can not presently accommodate Commercial Motor Vehicles (CMV) projects. Therefore, at this time, Selective Traffic Enforcement Programs (STEP) CMV proposals must be submitted in writing. Forms and instructions for STEP CMV are available at the same link listed above. In the event that STEP CMV is added to the eGrants System during the proposal period, then a proposing agency may either submit proposals electronically or in writing.

Proposals submitted using the eGrants system must be submitted no later than **5 p.m., March 9, 2007**. The eGrants system will not allow proposal submission after this date and time. Proposals targeting STEP CMV in writing must be submitted to the nearest TxDOT district office, Attention Traffic Safety Specialist, or mailed directly to Terry Pence, Traffic Operations Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78702. Written STEP CMV proposals must be received by TxDOT no later than **5 p.m., March 9, 2007**. Proposals received after this due date will not be accepted.

Video Conference training on submitting proposals for the new web based grants management system, eGrants, will be offered at various

TxDOT locations across the state. Please contact Traffic Safety Specialists in your area or send a note to eGrants@dot.state.tx.us to learn about locations near you.

Potential subgrantees may attend eGrants proposal submittal training on one of these dates:

January 17 and 18, 2007

February 14 and 15, 2007

If you have questions please contact Ms. Susan Warren at (512) 416-3177 or at swarre1@dot.state.tx.us in the TxDOT Traffic Operations Division, Traffic Safety Section.

TRD-200606897
Bob Jackson
General Counsel
Texas Department of Transportation
Filed: December 22, 2006

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The University of Texas System

Award of Consultant Contract Notification

The University of Texas Health Science Center at Houston (UTHSC-Houston)

The University of Texas Health Science Center at Houston ("University"), in accordance with the provisions of *Texas Government Code*, Chapter 2254, entered into a contract for consulting services (the "Contract") with Chrisman Group Public Relations ("Consultant") as more particularly described in the IFO 744-6035-COMMUNICATIONS AUDIT (the "Invitation"), published in the September 18, 2006, issue of the *Texas Register* (31 TexReg 8301).

Project Description:

In accordance with the Invitation and Consultant's response thereto, Consultant shall provide University with an institutional communications audit that will measure the effectiveness of internal and external communications vehicles throughout the University.

Scope of Work

In performing the Communications Audit, Consultant must:

(1) determine the degree of effectiveness of all communications within the University and the usefulness in supporting and advancing the University's strategic objectives,

(2) assess the overall effectiveness of the University's current marketing and communication efforts and recommend an approach for more efficient and productive collaboration and teamwork at the University,

(3) identify strategic issues facing the University that must be addressed to enable effective marketing for the UTHSC-H Medical School Physicians Practice Plan and the Memorial Hermann Healthcare System (MHHS), and

(4) make recommendations to the University that will allow a more integrated and strategic marketing unit to contribute significantly to the overall advancement of the University.

Consultant will provide the University with a final report for the Communications Audit, which must include, but is not limited to:

(1) an executive summary that identifies the degree of effectiveness among all of the University's internal and external vehicles of communications,

(2) current strengths and challenges in the current communications and marketing processes in place at the University,

(3) findings from interviews and research conducted by Consultant among the target audience for such interviews and research that is determined by the University and Consultant, and

(4) recommendations for new marketing and communication initiatives to enhance University effectiveness, which must be aligned with strategic goals of the University.

Consultant must complete the Communications Audit within the eight (8) to ten (10) consecutive calendar week period starting on the Effective Date.

Specifications

The Consultant shall provide the following services:

(a) Collect and review all internal and external communications within the University and conduct interviews with:

(1) University's senior administrators,

(2) selected members of the University's Development Board,

(3) University's academic deans,

(4) University's faculty,

(5) University relations department heads,

(6) University's department marketing managers,

(7) University's marketing, communications, and publication staff, and

(8) University's students

in order for the Consultant to provide the University with an in-depth analysis to determine if :

* the *University Communications Program* is increasing constituents and support for the University. Consultant will take inventory of the University's communications-internal and external, print, email, and web. Consultant will evaluate inventoried items for purpose, audience, usefulness, frequency, quality, consistency, goal attainment, and cost effectiveness, both individually and in combination with one another, in positioning the University and increasing University support.

* the *Media Relations Program* is increasing constituents and support for the University on a statewide and national level. Consultant will evaluate the usefulness, goal attainment, and cost effectiveness of media relations in positioning the University and increasing University support.

* the *Marketing and Community Relations Program* is increasing constituents and support for the University. Consultant will evaluate the purpose, audience, usefulness, quality, consistency, goal attainment, and cost effectiveness of marketing communications--including publications, signage, and graphic standards-in positioning the University and increasing University support.

* the University-wide organizational structure for the areas responsible for marketing communications are adequate. Consultant will evaluate staff competencies, responsibilities, and compensation; and determine if University's resource allotment/expenditures achieve University's communications goals and objectives.

(b) Conduct research of University communications and marketing messages from UTHSC-Houston, its schools, and its other units. Using qualitative and quantitative research, Consultant will provide University with Consultant's opinions about the usefulness, frequency, quality, consistency, and effectiveness of the University's communications and messages. Consultant will propose a market research

plan with specific goals and objectives using methodologies that may include, but are not limited to:

* focus groups,

* surveys, and

* in-depth interviews.

(c) At all times during its performance of the Communications Audit, Consultant will provide weekly progress reports to Charles "Bill" McClain, Assistant to the President of UTHSC-Houston and Dr. Randa Safady, Vice Chancellor for External Relations of the University of Texas System.

(d) At the conclusion of the Communications Audit, Consultant will provide the University with a *Final Report and Recommendations*, which will include Consultant's conduct of an oral presentation to the University's Executive Leaders (i.e. President, Vice President(s), Vice Chancellor for External Relations, Academic Dean(s), etc.) in addition to Consultant's preparing and providing a written report to the University, both of which will contain:

* an executive summary;

* detail of the scope of the work performed by Consultant in performing the Communications Audit, including the methodologies used by Consultant in perform the Audit;

* Consultant's major findings resulting from the Communications Audit , including Consultant's findings and recommendations for what the University's expectations, measures and benchmarks should be for the communications and marketing program at the University, an academic health science center located in the largest medical center in the world and in the fourth largest city in the United States;

* conclusions based on the Consultant's findings resulting from its performance of the Communications Audit;

* recommendations with budgetary estimates, implementation plans, a proposed University structure, and metrics that the University can employ to monitor its future success and progress toward strategic communication and marketing goals.

Delivery Schedule of Events and Time Periods (the "Timetable"):

Week 1:

* As soon as possible following the Effective Date, the University will assemble and provide to Consultant copies of all communications and marketing materials, research, reports, paper system, and other documents and publications it believes will be important for Consultant to review and analyze.

* Consultant and the University liaison will meet to confirm specific details of the Communications Audit. Once confirmed, such specific details will be recorded in writing by Consultant and University and executed by authorized officials of both parties. Once so executed, this detail document will be incorporated into this Agreement for all purposes.

* Together, Consultant and the University will finalize details of the Audit and agree to or modify this Timetable. Specific duties and assignments will be outlined and appropriate deadlines will be assigned to University and Consultant, and a detailed written *Work Plan* will be created and executed by authorized officials of both parties. Once so executed, this *Work Plan* will be incorporated into this Agreement for all purposes.

* Contractor will draft and provide the University a list of potential questions to be included in the *Management Interviews* and *Surveys*. The University must approve the *Management Interviews* and *Surveys* (including all questions to be used by Consultant) before Consultant uses such *Management Interviews* and *Surveys* in its performance of the Communications Audit. Furthermore, Consultant will not use any questions in its performance of the Communications Audit except those documented in the *Management Interviews* and *Surveys*.

Week 2:

* Consultant will begin reviewing and evaluating University research, publications, review industry issues.

* Consultant will begin interviews of selected University administrators, members of the Development Board, academic deans, faculty, and staffers for the *Management Interviews* section as well as *Surveys*.

* Consultant and University will document in writing the requirements that Consultant must meet in conducting focus groups in the course of its performance of the Communications Audit. Once completed, such focus group documentation will be executed by authorized officials of both parties and thereby be incorporated into this Agreement for all purposes. Such focus group documentation will include the questions that Consultant will ask the participants in such focus groups. Consultant will create and submit a draft of these questions to the University; however, the University must approve in advance all questions that Consultant uses in conducting the focus groups.

Week 3:

* Consultant continues to review and evaluate University research and publications.

* Consultant continues to conduct *Management Interviews*, *Surveys*.

* Consultant begins transcription and evaluation of *Management Interviews*.

* Consultant works with University liaison to begin coordination of Focus Groups.

Week 4:

* Consultant continues *Management Interviews*.

* Consultant begins transcription of *Surveys*results.

* Consultant begins Focus Groups, facilitated by Dale Chrisman.

* Consultant begins draft of *Final Report and Recommendations* on effectiveness of University publications, communications, and marketing tools.

Week 5:

* Consultant continues *Management Interviews*, begins drafting the *Management Interviews* section of the Final Report and Recommendations.

* Consultant continues Focus Groups.

* Consultant continues draft of *Final Report and Recommendations* on publications, etc.

Week 6:

* Consultant completes and begins final edits to transcriptions of Focus Groups.

* Consultant completes editing of the sections of the *Final Report and Recommendations* on *Management Interviews* and Report on publications.

Weeks 7 and 8:

* Consultant begins work on first draft of *Final Report and Recommendations*.

* Consultant meets with the University liaison to review first draft of *Final Report and Recommendations*.

Week 9:

* Consultant edits Final Report and Recommendations, begins printing, binding of *Final Report and Recommendations*.

Week 10:

* Consultant presents and delivers Final Report and Recommendations to University's Executive Leaders (President, Vice President(s), Vice Chancellor for External Relations, Academic Deans, and whomever else the University chooses.

* Consultant will also deliver a copy of the *Final Report and Recommendations* to:

The University of Texas Health Science Center at Houston

1851 Crosspoint, OCB 1.160

Houston, Texas 77054

Fax: (713) 500-4710

Email: Samantha.B.Lai@uth.tmc.edu

Attention: Samantha Lai, C.T.P.

Name and Address of Consultant:

Chrisman Group Public Relations

3409 Executive Center Drive, Suite 120

Austin, Texas 78731

Total Value of the Contract:

The total value of the Contract will not exceed $33,000.00.

University's standard payment terms for services are "Net 30 days." Chrisman Group Public Relations agrees that University will be entitled to withhold thirty-three percent (33%) of the total Services Fees due under this Agreement until after the University's acceptance of the *Final Report and Recommendations* provided by Consultant. In addition, Consultant provides the University with the following prompt payment discount on all early payments that the University makes under this Agreement:

Prompt Payment Discount: 5% 10 days/net 30 days.

Contract Dates:

The Contract was executed by Consultant on December 29, 2006, and by University on December 27, 2006, and dated effective January 1, 2007.

Due Dates for Contract Products:

Final Report and Recommendations related to the Communications Audit shall be completed and delivered to University the week of March 26, 2006, and no later than March 30, 2007 at 5:00 PM CST.

The term of the Contract shall terminate on March 30, 2007.

TRD-200700006
Francie A. Frederick
General Counsel to the Board of Regents
The University of Texas System
Filed: January 3, 2007

How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 30 (2005) is cited as follows: 30 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "30 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 30 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For website subscription information, call the Texas Register at (800) 226-7199.

Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (1-800-356-6548), and West Publishing Company (1-800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 21, April 15, July 8, and October 7, 2005). If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).